

118TH CONGRESS
1ST SESSION

H. R. 4822

To improve price transparency with respect to certain health care services,
and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 24, 2023

Mr. SMITH of Missouri introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and the Workforce, and the Budget, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To improve price transparency with respect to certain health
care services, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Health Care Price Transparency Act of 2023”.

6 (b) TABLE OF CONTENTS.—The table of contents for
7 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—HEALTH CARE PRICE TRANSPARENCY FOR PATIENTS

- Sec. 101. Requiring certain facilities under the Medicare program to disclose certain information relating to charges and prices.
- Sec. 102. Promoting group health plan price transparency.
- Sec. 103. Oversight of pharmacy benefits manager services.
- Sec. 104. Reports on health care transparency tools and data requirements.
- Sec. 105. Report on integration in Medicare.

TITLE II—FAIR PRICES FOR PATIENTS

- Sec. 201. Limitation on cost sharing to net price amount under Medicare part D.
- Sec. 202. Requiring a separate identification number and an attestation for each off-campus outpatient department of a provider.
- Sec. 203. Parity in Medicare payments for hospital outpatient department services furnished off-campus.

TITLE III—PATIENT-FOCUSED INVESTMENTS

- Sec. 301. Establishing requirements with respect to the use of prior authorization under Medicare Advantage plans.
- Sec. 302. Extension of certain direct spending reductions.

1 TITLE I—HEALTH CARE PRICE

2 TRANSPARENCY FOR PATIENTS

3 SEC. 101. REQUIRING CERTAIN FACILITIES UNDER THE

4 MEDICARE PROGRAM TO DISCLOSE CERTAIN

5 INFORMATION RELATING TO CHARGES AND

6 PRICES.

7 (a) IN GENERAL.—Part E of title XVIII of the Social

8 Security Act (42 U.S.C. 1395x et seq.) is amended by add-

9 ing at the end the following new section:

10 “SEC. 1899C. HEALTH CARE PROVIDER PRICE TRANS-

11 PARENCY.

12 “(a) HOSPITAL PRICE TRANSPARENCY.—

13 “(1) IN GENERAL.—Beginning January 1,

14 2026, each specified hospital (as defined in para-

15 graph (6)) that receives payment under this title for

16 furnishing items and services shall comply with the

1 price transparency requirement described in para-
2 graph (2).

3 “(2) REQUIREMENT DESCRIBED.—

4 “(A) IN GENERAL.—For purposes of para-
5 graph (1), the price transparency requirement
6 described in this paragraph is, with respect to
7 a specified hospital, that such hospital, in ac-
8 cordance with a method and format established
9 by the Secretary under subparagraph (C), com-
10 pile and make public (without subscription and
11 free of charge) for each year—

12 “(i) one or more lists, in a format
13 specified by the Secretary (which may be a
14 machine-readable format), of the hospital’s
15 standard charges (including the informa-
16 tion described in subparagraph (B)) for
17 each item and service furnished by such
18 hospital; and

19 “(ii) information in a consumer-
20 friendly format (as specified by the Sec-
21 retary)—

22 “(I) on the hospital’s prices (in-
23 cluding the information described in
24 subparagraph (B)) for as many of the
25 Centers for Medicare & Medicaid

1 Services-specified shoppable services
2 that are furnished by the hospital,
3 and as many additional hospital-se-
4 lected shoppable services (or all such
5 additional services, if such hospital
6 furnishes fewer than 300 shoppable
7 services) as may be necessary for a
8 combined total of at least 300
9 shoppable services; and

10 “(II) that includes, with respect
11 to each Centers for Medicare & Med-
12 icaid Services-specified shoppable
13 service that is not furnished by the
14 hospital, an indication that such serv-
15 ice is not so furnished.

16 “(B) INFORMATION DESCRIBED.—For pur-
17 poses of subparagraph (A), the information de-
18 scribed in this subparagraph is, with respect to
19 standard charges and prices (as applicable)
20 made public by a specified hospital, the fol-
21 lowing:

22 “(i) A description of each item or
23 service, accompanied by, as applicable, the
24 Healthcare Common Procedure Coding
25 System code, the diagnosis-related group,

1 the national drug code, or other identifier
2 used or approved by the Centers for Medi-
3 care & Medicaid Services.

4 “(ii) The gross charge, expressed as a
5 dollar amount, for each such item or serv-
6 ice, when provided in, as applicable, the in-
7 patient setting and outpatient department
8 setting.

9 “(iii) The discounted cash price, ex-
10 pressed as a dollar amount, for each such
11 item or service when provided in, as appli-
12 cable, the inpatient setting and outpatient
13 department setting (or, in the case no dis-
14 counted cash price is available for an item
15 or service, the median price charged by the
16 hospital for such item or service when pro-
17 vided in such settings for the previous
18 three years, expressed as a dollar amount).

19 “(iv) Any other information the Sec-
20 retary may require for purposes of pro-
21 moting public awareness of specified hos-
22 pital standard charges or prices in advance
23 of receiving an item or service from such
24 a hospital, except information that is dupli-
25 cative of any other reporting requirement

1 under this section. Such information may
2 include any current payer-specific nego-
3 tiated charges, clearly associated with the
4 name of the third party payer and plan
5 and expressed as a dollar amount, that
6 apply to each such item or service when
7 provided in, as applicable, the inpatient
8 setting and outpatient department setting.

9 “(C) METHOD AND FORMAT.—Not later
10 than January 1, 2026, the Secretary shall es-
11 tablish one or more methods and formats for
12 specified facilities to use in compiling and mak-
13 ing public standard charges and prices (as ap-
14 plicable) pursuant to subparagraph (A). Any
15 such method and format—

16 “(i) may be similar to any template
17 made available by the Centers for Medicare
18 & Medicaid Services as of the date of the
19 enactment of this subparagraph;

20 “(ii) shall meet such standards as de-
21 termined appropriate by the Secretary in
22 order to ensure the accessibility and
23 usability of such charges and prices; and

1 “(iii) shall be updated as determined
2 appropriate by the Secretary, in consulta-
3 tion with stakeholders.

4 “(3) DEEMED COMPLIANCE WITH SHOPPABLE
5 SERVICES REQUIREMENT FOR HOSPITALS WITH A
6 PRICE ESTIMATOR TOOL.—

7 “(A) IN GENERAL.—With respect to each
8 year until the effective date of regulations im-
9 plementing the provisions of sections 2799A–
10 1(f) and 2799B–6 of the Public Health Service
11 Act (relating to advanced explanations of bene-
12 fits), including regulations on establishing data
13 transfer standards to effectuate such provisions,
14 a specified hospital shall be deemed to have
15 complied with the requirement described in
16 paragraph (2)(A)(ii)(I) (relating to shoppable
17 services) if such hospital maintains a price esti-
18 mator tool described in subparagraph (B).

19 “(B) PRICE ESTIMATOR TOOL DE-
20 SCRIBED.—For purposes of subparagraph (A),
21 the price estimator tool described in this sub-
22 paragraph is, with respect to a specified hos-
23 pital, a tool that meets the following require-
24 ments:

1 “(i) Such tool allows an individual to
2 immediately obtain a price estimate (tak-
3 ing into account whether such individual is
4 covered under any plan, coverage, or pro-
5 gram described in clause (iv)(III)) and the
6 discounted cash price charged by a speci-
7 fied hospital, for each Centers for Medicare
8 & Medicaid Services-specified shoppable
9 service that is furnished by such hospital,
10 and for each additional shoppable service
11 as such hospital may select, such that price
12 estimates are available through such tool
13 for at least 300 shoppable services (or for
14 all such services, if such hospital furnishes
15 fewer than 300 shoppable services).

16 “(ii) Such tool allows an individual to
17 obtain such an estimate by billing code and
18 by service description.

19 “(iii) Such tool is prominently dis-
20 played on the public internet website of
21 such hospital.

22 “(iv) Such tool does not require an in-
23 dividual seeking such an estimate to create
24 an account or otherwise input personal in-
25 formation, except that such tool may re-

1 require that such individual provide informa-
2 tion specified by the Secretary, which may
3 include the following:

4 “(I) The name of such individual.

5 “(II) The date of birth of such
6 individual.

7 “(III) In the case such individual
8 is covered under a group health plan,
9 group or individual health insurance
10 coverage, a Federal health care pro-
11 gram, or the program established
12 under chapter 89 of title 5, United
13 States Code, an identifying number
14 assigned by such plan, coverage, or
15 program to such individual.

16 “(IV) In the case of an individual
17 described in subclause (III), an indi-
18 cation as to whether such individual is
19 the primary insured individual under
20 such plan, coverage, or program (and,
21 if such individual is not the primary
22 insured individual, a description of the
23 individual’s relationship to such pri-
24 mary insured individual).

1 “(V) Any other information spec-
2 ified by the Secretary.

3 “(v) Such tool contains a statement
4 confirming the accuracy and completeness
5 of information presented through such tool
6 as of the date such request is made.

7 “(vi) Such tool meets any other re-
8 quirement specified by the Secretary.

9 “(4) MONITORING COMPLIANCE.—The Sec-
10 retary shall, through notice and comment rule-
11 making and in consultation with the Inspector Gen-
12 eral of the Department of Health and Human Serv-
13 ices, establish a process to monitor compliance with
14 this subsection. Such process shall ensure that each
15 specified hospital’s compliance with this subsection
16 is reviewed not less frequently than once every 3
17 years.

18 “(5) ENFORCEMENT.—

19 “(A) IN GENERAL.—In the case of a speci-
20 fied hospital that fails to comply with the re-
21 quirements of this subsection—

22 “(i) the Secretary shall notify such
23 hospital of such failure not later than 30
24 days after the date on which the Secretary
25 determines such failure exists; and

1 “(ii) upon request of the Secretary,
2 the hospital shall submit to the Secretary,
3 not later than 45 days after the date of
4 such request, a corrective action plan to
5 comply with such requirements.

6 “(B) CIVIL MONETARY PENALTY.—

7 “(i) IN GENERAL.—In addition to any
8 other enforcement actions or penalties that
9 may apply under another provision of law,
10 a specified hospital that has received a no-
11 tification under subparagraph (A)(i) and
12 fails to comply with the requirements of
13 this subsection by the date that is 90 days
14 after such notification (or, in the case of
15 such a hospital that has submitted a cor-
16 rective action plan described in subpara-
17 graph (A)(ii) in response to a request so
18 described, by the date that is 90 days after
19 the Secretary identifies the failure of such
20 hospital to satisfactorily complete such cor-
21 rective action plan) shall be subject to a
22 civil monetary penalty of an amount speci-
23 fied by the Secretary for each subsequent
24 day during which such failure is ongoing.
25 Such amount shall not exceed—

1 “(I) in the case of a specified
2 hospital that is a hospital or critical
3 access hospital with 30 or fewer beds,
4 \$300 per day; and

5 “(II) in the case of any specified
6 hospital and except as provided in
7 clause (iii), \$2,000,000 for a 1-year
8 period.

9 “(ii) INCREASE AUTHORITY.—In ap-
10 plying this subparagraph with respect to
11 violations occurring in 2027 or a subse-
12 quent year, the Secretary may through no-
13 tice and comment rulemaking increase—

14 “(I) the limitation on the per day
15 amount of any penalty applicable to a
16 specified hospital that is a hospital or
17 critical access hospital with 30 or
18 fewer beds under clause (i)(I);

19 “(II) the limitation on the
20 amount of any penalty applicable for
21 a 1-year period under clause (i)(II);
22 and

23 “(III) the limitation on the in-
24 crease of any penalty applied under
25 clause (iii).

1 “(iii) PERSISTENT NONCOMPLI-
2 ANCE.—In the case of a specified hospital
3 (other than a specified hospital that is a
4 hospital or critical access hospital with 30
5 or fewer beds) that the Secretary has de-
6 termined to be knowingly and willfully non-
7 compliant with the provisions of this sub-
8 section two or more times during a 1-year
9 period, the Secretary may increase any
10 penalty otherwise applicable under this
11 subparagraph by not more than
12 \$1,000,000 and may require such hospital
13 to complete such additional corrective ac-
14 tions plans as the Secretary may specify.

15 “(iv) APPLICATION OF CERTAIN PRO-
16 VISIONS.—The provisions of section 1128A
17 (other than subsections (a) and (b) of such
18 section) shall apply to a civil monetary
19 penalty imposed under this subparagraph
20 in the same manner as such provisions
21 apply to a civil monetary penalty imposed
22 under subsection (a) of such section.

23 “(v) AUTHORITY TO WAIVE OR RE-
24 DUCE PENALTY.—The Secretary may
25 waive or reduce any penalty otherwise ap-

1 plicable with respect to a specified hospital
2 under this subparagraph if the Secretary
3 determines that imposition of such penalty
4 would result in a significant hardship for
5 such hospital (such as in the case of a hos-
6 pital located in a rural or underserved area
7 where imposition of such penalty may re-
8 sult in, or contribute to, a lack of access
9 to care for individuals in such area).

10 “(C) PUBLICATION OF HOSPITAL PRICE
11 TRANSPARENCY INFORMATION.—Beginning on
12 January 1, 2026, the Secretary shall make pub-
13 licly available on the public website of the Cen-
14 ters for Medicare & Medicaid Services informa-
15 tion with respect to compliance with the re-
16 quirements of this subsection and enforcement
17 activities undertaken by the Secretary under
18 this subsection. Such information shall be up-
19 dated not less than annually and include, with
20 respect to each year—

21 “(i) the number of reviews of compli-
22 ance with this subsection undertaken by
23 the Secretary;

1 “(ii) the number of notifications de-
2 scribed in subparagraph (A)(i) sent by the
3 Secretary;

4 “(iii) the identify of each specified
5 hospital that was sent such a notification
6 and a description of the nature of such
7 hospital’s noncompliance with this sub-
8 section;

9 “(iv) the amount of any civil monetary
10 penalty imposed on such hospital under
11 subparagraph (B);

12 “(v) whether such hospital subse-
13 quently came into compliance with this
14 subsection; and

15 “(vi) any other information as deter-
16 mined by the Secretary.

17 “(6) DEFINITIONS.—For purposes of this sub-
18 section:

19 “(A) DISCOUNTED CASH PRICE.—The
20 term ‘discounted cash price’ means the charge
21 that applies to an individual who pays cash, or
22 cash equivalent, for a specified hospital-fur-
23 nished item or service.

1 “(B) FEDERAL HEALTH CARE PROGRAM.—

2 The term ‘Federal health care program’ has the
3 meaning given such term in section 1128B.

4 “(C) GROSS CHARGE.—The term ‘gross
5 charge’ means the charge for an individual item
6 or service that is reflected on a specified hos-
7 pital’s chargemaster, absent any discounts.

8 “(D) GROUP HEALTH PLAN; GROUP
9 HEALTH INSURANCE COVERAGE; INDIVIDUAL
10 HEALTH INSURANCE COVERAGE.—The terms
11 ‘group health plan’, ‘group health insurance
12 coverage’, and ‘individual health insurance cov-
13 erage’ have the meaning given such terms in
14 section 2791 of the Public Health Service Act.

15 “(E) PAYER-SPECIFIC NEGOTIATED
16 CHARGE.—The term ‘payer-specific negotiated
17 charge’ means the charge that a specified hos-
18 pital has negotiated with a third party payer for
19 an item or service.

20 “(F) SHOPPABLE SERVICE.—The term
21 ‘shoppable service’ means a service that can be
22 scheduled by a health care consumer in advance
23 and includes all ancillary items and services
24 customarily furnished as part of such service.

1 “(G) SPECIFIED HOSPITAL.—The term
2 ‘specified hospital’ means a hospital (as defined
3 in section 1861(e)), a critical access hospital (as
4 defined in section 1861(mmm)(1)), or a rural
5 emergency hospital (as defined in section
6 1861(kkk)).

7 “(H) THIRD PARTY PAYER.—The term
8 ‘third party payer’ means an entity that is, by
9 statute, contract, or agreement, legally respon-
10 sible for payment of a claim for a health care
11 item or service.

12 “(b) AMBULATORY SURGICAL CENTER PRICE
13 TRANSPARENCY.—

14 “(1) IN GENERAL.—Beginning January 1,
15 2028, each ambulatory surgical center that receives
16 payment under this title for furnishing items and
17 services shall comply with the price transparency re-
18 quirement described in paragraph (2).

19 “(2) REQUIREMENT DESCRIBED.—

20 “(A) IN GENERAL.—For purposes of para-
21 graph (1), the price transparency requirement
22 described in this subsection is, with respect to
23 an ambulatory surgical center, that such sur-
24 gical center in accordance with a method and
25 format established by the Secretary under sub-

1 paragraph (C)), compile and make public (with-
2 out subscription and free of charge), for each
3 year—

4 “(i) one or more lists, in a format
5 specified by the Secretary, of the ambula-
6 tory surgical center’s standard charges (in-
7 cluding the information described in sub-
8 paragraph (B)) for each item and service
9 furnished by such surgical center;

10 “(ii) information on the ambulatory
11 surgical center’s prices (including the in-
12 formation described in subparagraph (B))
13 for as many of the Centers for Medicare &
14 Medicaid Services-specified shoppable serv-
15 ices that are furnished by such surgical
16 center, and as many additional ambulatory
17 surgical center-selected shoppable services
18 (or all such additional services, if such sur-
19 gical center furnishes fewer than 300
20 shoppable services) as may be necessary
21 for a combined total of at least 300
22 shoppable services;

23 “(iii) with respect to each Centers for
24 Medicare & Medicaid Services-specified
25 shoppable service that is not furnished by

1 the ambulatory surgical center, an indica-
2 tion that such service is not so furnished;
3 and

4 “(iv) any additional information speci-
5 fied by the Secretary.

6 “(B) INFORMATION DESCRIBED.—For pur-
7 poses of subparagraph (A), the information de-
8 scribed in this subparagraph is, with respect to
9 standard charges and prices (as applicable)
10 made public by an ambulatory surgical center,
11 the following:

12 “(i) A description of each item or
13 service, accompanied by, as applicable, the
14 Healthcare Common Procedure Coding
15 System code, the diagnosis-related group,
16 the national drug code, or other identifier
17 used or approved by the Centers for Medi-
18 care & Medicaid Services.

19 “(ii) The gross charge, expressed as a
20 dollar amount, for each such item or serv-
21 ice.

22 “(iii) The discounted cash price, ex-
23 pressed as a dollar amount, for each such
24 item or service (or, in the case no dis-
25 counted cash price is available for an item

1 or service, the gross charge for such item
2 or service for the previous three years, ex-
3 pressed as a dollar amount).

4 “(iv) Any other information the Sec-
5 retary may require that is not duplicative
6 of any other reporting requirement under
7 this subsection for purposes of promoting
8 public awareness of ambulatory surgical
9 center prices in advance of receiving an
10 item or service from such an ambulatory
11 surgical center, which may include any
12 current payer-specific negotiated charges,
13 clearly associated with the name of the
14 third party payer and plan and expressed
15 as a dollar amount, that applies to each
16 such item or service.

17 “(C) METHOD AND FORMAT.—Not later
18 than January 1, 2028, the Secretary shall es-
19 tablish one or more methods and formats for
20 ambulatory surgical centers to use in making
21 public standard charges and prices (as applica-
22 ble) pursuant to subparagraph (A). Any such
23 method and format—

24 “(i) may be similar to any template
25 made available by the Centers for Medicare

1 & Medicaid Services as of the date of the
2 enactment of this paragraph;

3 “(ii) shall meet such standards as de-
4 termined appropriate by the Secretary in
5 order to ensure the accessibility and
6 usability of such charges and prices; and

7 “(iii) shall be updated as determined
8 appropriate by the Secretary, in consulta-
9 tion with stakeholders.

10 “(3) DEEMED COMPLIANCE WITH SHOPPABLE
11 SERVICES REQUIREMENT FOR AMBULATORY SUR-
12 GICAL CENTERS WITH A PRICE ESTIMATOR TOOL.—

13 “(A) IN GENERAL.—An ambulatory sur-
14 gical center shall be deemed to have complied
15 with the requirement described in subsection
16 (b)(2)(A) (relating to shoppable services) if
17 such surgical center maintains a price estimator
18 tool described in subparagraph (B).

19 “(B) PRICE ESTIMATOR TOOL DE-
20 SCRIBED.—For purposes of subparagraph (A),
21 the price estimator tool described in this sub-
22 paragraph is, with respect to an ambulatory
23 surgical center, a tool that meets the following
24 requirements:

1 “(i) Such tool allows an individual to
2 immediately obtain a price estimate (tak-
3 ing into account whether such individual is
4 covered under any plan, coverage, or pro-
5 gram described in clause (iv)(III)) for each
6 Centers for Medicare & Medicaid Services-
7 specified shoppable service that is fur-
8 nished by such surgical center, and for
9 each additional shoppable service as such
10 surgical center may select, such that price
11 estimates are available through such tool
12 for at least 300 shoppable services (or for
13 all such services, if such surgical center
14 furnishes fewer than 300 shoppable serv-
15 ices).

16 “(ii) Such tool allows an individual to
17 obtain such an estimate by billing code and
18 by service description.

19 “(iii) Such tool is prominently dis-
20 played on the public internet website of
21 such ambulatory surgical center.

22 “(iv) Such tool does not require an in-
23 dividual seeking such an estimate to create
24 an account or otherwise input personal in-
25 formation, except that such tool may re-

1 require that such individual provide informa-
2 tion specified by the Secretary, which may
3 include the following:

4 “(I) The name of such individual.

5 “(II) The date of birth of such
6 individual.

7 “(III) In the case such individual
8 is covered under a group health plan,
9 group or individual health insurance
10 coverage, a Federal health care pro-
11 gram, or the program established
12 under chapter 89 of title 5, United
13 States Code, an identifying number
14 assigned by such plan, coverage, or
15 program to such individual.

16 “(IV) In the case of an individual
17 described in subclause (III), an indi-
18 cation as to whether such individual is
19 the primary insured individual under
20 such plan, coverage, or program (and,
21 if such individual is not the primary
22 insured individual, a description of the
23 individual’s relationship to such pri-
24 mary insured individual).

1 “(V) Any other information spec-
2 ified by the Secretary.

3 “(v) Such tool contains a statement
4 confirming the accuracy and completeness
5 of information presented through such tool
6 as of the date such request is made.

7 “(vi) Such tool meets any other re-
8 quirement specified by the Secretary.

9 “(4) MONITORING COMPLIANCE.—The Sec-
10 retary shall, through notice and comment rule-
11 making and in consultation with the Inspector Gen-
12 eral of the Department of Health and Human Serv-
13 ices, establish a process to monitor compliance with
14 this subsection. Such process shall ensure that each
15 ambulatory surgical center’s compliance with this
16 subsection is reviewed not less frequently than once
17 every 3 years.

18 “(5) ENFORCEMENT.—

19 “(A) IN GENERAL.—In the case of an am-
20 bulatory surgical center that fails to comply
21 with the requirements of this subsection—

22 “(i) the Secretary shall notify such
23 ambulatory surgical center of such failure
24 not later than 30 days after the date on

1 which the Secretary determines such fail-
2 ure exists; and

3 “(ii) upon request of the Secretary,
4 the ambulatory surgical center shall submit
5 to the Secretary, not later than 45 days
6 after the date of such request, a corrective
7 action plan to comply with such require-
8 ments.

9 “(B) CIVIL MONETARY PENALTY.—

10 “(i) IN GENERAL.—In addition to any
11 other enforcement actions or penalties that
12 may apply under another provision of law,
13 an ambulatory surgical center that has re-
14 ceived a notification under subparagraph
15 (A)(i) and fails to comply with the require-
16 ments of this subsection by the date that
17 is 90 days after such notification (or, in
18 the case of an ambulatory surgical center
19 that has submitted a corrective action plan
20 described in subparagraph (A)(ii) in re-
21 sponse to a request so described, by the
22 date that is 90 days after such submission)
23 shall be subject to a civil monetary penalty
24 of an amount specified by the Secretary for
25 each subsequent day during which such

1 failure is ongoing (not to exceed \$300 per
2 day).

3 “(ii) INCREASE AUTHORITY.—In ap-
4 plying this subparagraph with respect to
5 violations occurring in 2027 or a subse-
6 quent year, the Secretary may through no-
7 tice and comment rulemaking increase the
8 limitation on the per day amount of any
9 penalty applicable to an ambulatory sur-
10 gical center under clause (i).

11 “(iii) APPLICATION OF CERTAIN PRO-
12 VISIONS.—The provisions of section 1128A
13 (other than subsections (a) and (b) of such
14 section) shall apply to a civil monetary
15 penalty imposed under this subparagraph
16 in the same manner as such provisions
17 apply to a civil monetary penalty imposed
18 under subsection (a) of such section.

19 “(iv) AUTHORITY TO WAIVE OR RE-
20 DUCE PENALTY.—The Secretary may
21 waive or reduce any penalty otherwise ap-
22 plicable with respect to an ambulatory sur-
23 gical center under this subparagraph if the
24 Secretary determines that imposition of
25 such penalty would result in a significant

1 hardship for such ambulatory surgical cen-
2 ter (such as in the case of an ambulatory
3 surgical center located in a rural or under-
4 served area where imposition of such pen-
5 alty may result in, or contribute to, a lack
6 of access to care for individuals in such
7 area).

8 “(6) DEFINITIONS.—For purposes of this sec-
9 tion:

10 “(A) DISCOUNTED CASH PRICE.—The
11 term ‘discounted cash price’ means the charge
12 that applies to an individual who pays cash, or
13 cash equivalent, for a item or service furnished
14 by an ambulatory surgical center.

15 “(B) FEDERAL HEALTH CARE PROGRAM.—
16 The term ‘Federal health care program’ has the
17 meaning given such term in section 1128B.

18 “(C) GROSS CHARGE.—The term ‘gross
19 charge’ means the charge for an individual item
20 or service that is reflected on a specified sur-
21 gical center’s chargemaster, absent any dis-
22 counts.

23 “(D) GROUP HEALTH PLAN; GROUP
24 HEALTH INSURANCE COVERAGE; INDIVIDUAL
25 HEALTH INSURANCE COVERAGE.—The terms

1 ‘group health plan’, ‘group health insurance
2 coverage’, and ‘individual health insurance cov-
3 erage’ have the meaning given such terms in
4 section 2791 of the Public Health Service Act.

5 “(E) PAYER-SPECIFIC NEGOTIATED
6 CHARGE.—The term ‘payer-specific negotiated
7 charge’ means the charge that a specified sur-
8 gical center has negotiated with a third party
9 payer for an item or service.

10 “(F) SHOPPABLE SERVICE.—The term
11 ‘shoppable service’ means a service that can be
12 scheduled by a health care consumer in advance
13 and includes all ancillary items and services
14 customarily furnished as part of such service.

15 “(G) THIRD PARTY PAYER.—The term
16 ‘third party payer’ means an entity that is, by
17 statute, contract, or agreement, legally respon-
18 sible for payment of a claim for a health care
19 item or service.

20 “(c) IMAGING SERVICES PRICE TRANSPARENCY.—

21 “(1) IN GENERAL.—Beginning January 1,
22 2025, each provider of services and supplier that re-
23 ceives payment under this title for furnishing a spec-
24 ified imaging service shall—

1 “(A) make publicly available (in a form
2 and manner specified by the Secretary) on an
3 Internet website the information described in
4 paragraph (2) with respect to each such service
5 that such provider of services or supplier fur-
6 nishes; and

7 “(B) ensure that such information is up-
8 dated not less frequently than annually.

9 “(2) INFORMATION DESCRIBED.—For purposes
10 of paragraph (1), the information described in this
11 subsection is, with respect to a provider of services
12 or supplier and a specified imaging service, the fol-
13 lowing:

14 “(A) The discounted cash price for such
15 service (or, if no such price exists, the gross
16 charge for such service).

17 “(B) If required by the Secretary, the
18 deidentified minimum negotiated rate in effect
19 between such provider or supplier and any
20 group health plan or group or individual health
21 insurance coverage for such service and the
22 deidentified maximum negotiated rate in effect
23 between such provider or supplier and any such
24 plan or coverage for such service.

1 “(3) METHOD AND FORMAT.—Not later than
2 January 1, 2028, the Secretary shall establish one
3 or more methods and formats for each provider of
4 services and supplier to use in compiling and making
5 public standard charges and prices (as applicable)
6 pursuant to paragraph (1). Any such method and
7 format—

8 “(A) may be similar to any template made
9 available by the Centers for Medicare & Med-
10 icaid Services as of the date of the enactment
11 of this subsection;

12 “(B) shall meet such standards as deter-
13 mined appropriate by the Secretary in order to
14 ensure the accessibility and usability of such
15 charges and prices; and

16 “(C) shall be updated as determined ap-
17 propriate by the Secretary, in consultation with
18 stakeholders.

19 “(4) MONITORING COMPLIANCE.—The Sec-
20 retary shall, through notice and comment rule-
21 making and in consultation with the Inspector Gen-
22 eral of the Department of Health and Human Serv-
23 ices, establish a process to monitor compliance with
24 this subsection.

1 “(5) SPECIFICATION OF SERVICES.—Not later
2 than January 1, 2025, the Secretary shall publish a
3 list of at least 50 imaging services that the Sec-
4 retary determines are shoppable (or all such services,
5 if the Secretary determines that fewer than 50 such
6 services are shoppable) between providers of services
7 and suppliers of such services. The Secretary shall
8 update such list as determined appropriate by the
9 Secretary.

10 “(6) ENFORCEMENT.—

11 “(A) IN GENERAL.—In the case that the
12 Secretary determines that a provider of services
13 or supplier is not in compliance with paragraph
14 (1)—

15 “(i) not later than 30 days after such
16 determination, the Secretary shall notify
17 such provider or supplier of such deter-
18 mination;

19 “(ii) upon request of the Secretary,
20 such provider or supplier shall submit to
21 the Secretary, not later than 45 days after
22 the date of such request, a corrective ac-
23 tion plan to comply with such paragraph;
24 and

1 “(iii) if such provider or supplier con-
2 tinues to fail to comply with such para-
3 graph after the date that is 90 days after
4 such notification is sent (or, in the case of
5 such a provider or supplier that has sub-
6 mitted a corrective action plan described in
7 clause (ii) in response to a request so de-
8 scribed, after the date that is 90 days after
9 such submission), the Secretary may im-
10 pose a civil monetary penalty in an amount
11 not to exceed \$300 for each subsequent
12 day during which such failure to comply or
13 failure to submit is ongoing.

14 “(B) INCREASE AUTHORITY.—In applying
15 this paragraph with respect to violations occur-
16 ring in 2027 or a subsequent year, the Sec-
17 retary may through notice and comment rule-
18 making increase the amount of the civil mone-
19 tary penalty under subparagraph (A)(iii).

20 “(C) APPLICATION OF CERTAIN PROVI-
21 SIONS.—The provisions of section 1128A (other
22 than subsections (a) and (b) of such section)
23 shall apply to a civil monetary penalty imposed
24 under this paragraph in the same manner as
25 such provisions apply to a civil monetary pen-

1 alty imposed under subsection (a) of such sec-
2 tion.

3 “(D) AUTHORITY TO WAIVE OR REDUCE
4 PENALTY.—The Secretary may waive or reduce
5 any penalty otherwise applicable with respect to
6 a provider of services or supplier under this
7 subparagraph if the Secretary determines that
8 imposition of such penalty would result in a sig-
9 nificant hardship for such provider or supplier
10 (such as in the case of a provider or supplier
11 located in a rural or underserved area where
12 imposition of such penalty may result in, or
13 contribute to, a lack of access to care for indi-
14 viduals in such area).

15 “(E) CLARIFICATION OF NONAPPLICA-
16 BILITY OF OTHER ENFORCEMENT PROVI-
17 SIONS.—Notwithstanding any other provision of
18 this title, this paragraph shall be the sole
19 means of enforcing the provisions of this sub-
20 section.

21 “(7) DEFINITIONS.—In this subsection:

22 “(A) GROUP HEALTH PLAN; GROUP
23 HEALTH INSURANCE COVERAGE; INDIVIDUAL
24 HEALTH INSURANCE COVERAGE.—The terms
25 ‘group health plan’, ‘group health insurance

1 coverage’, and ‘individual health insurance cov-
2 erage’ have the meaning given such terms in
3 section 2791 of the Public Health Service Act.

4 “(B) SPECIFIED IMAGING SERVICE.—the
5 term ‘specified imaging service’ means an imag-
6 ing service that is included on the list published
7 by the Secretary under subsection (e).

8 “(d) CLINICAL LABORATORY PRICE TRANS-
9 PARENCY.—

10 “(1) IN GENERAL.—Beginning January 1,
11 2025, each applicable laboratory that receives pay-
12 ment under this title for furnishing a specified clin-
13 ical diagnostic laboratory test shall—

14 “(A) make publicly available (in a manner
15 and form specified by the Secretary) on an
16 Internet website the information described in
17 paragraph (2) with respect to each such speci-
18 fied clinical diagnostic laboratory test that such
19 laboratory is so available to furnish; and

20 “(B) ensure that such information is up-
21 dated not less frequently than annually.

22 “(2) INFORMATION DESCRIBED.—For purposes
23 of paragraph (1), the information described in this
24 subsection is, with respect to an applicable labora-

1 tory and a specified clinical diagnostic laboratory
2 test, the following:

3 “(A) The discounted cash price for such
4 test (or, if no such price exists, the gross
5 charge for such test).

6 “(B) If required by the Secretary, the
7 deidentified minimum negotiated rate in effect
8 between such laboratory and any group health
9 plan or group or individual health insurance
10 coverage for such test and the deidentified max-
11 imum negotiated rate in effect between such
12 laboratory and any such plan or coverage for
13 such test.

14 “(3) METHOD AND FORMAT.—Not later than
15 January 1, 2028, the Secretary shall establish one
16 or more methods and formats for each provider of
17 services and supplier to use in compiling and making
18 public standard charges and prices (as applicable)
19 pursuant to paragraph (1). Any such method and
20 format—

21 “(A) may be similar to any template made
22 available by the Centers for Medicare & Med-
23 icaid Services as of the date of the enactment
24 of this subsection;

1 “(B) shall meet such standards as deter-
2 mined appropriate by the Secretary in order to
3 ensure the accessibility and usability of such
4 charges and prices; and

5 “(C) shall be updated as determined ap-
6 propriate by the Secretary, in consultation with
7 stakeholders.

8 “(4) MONITORING COMPLIANCE.—The Sec-
9 retary shall, through notice and comment rule-
10 making and in consultation with the Inspector Gen-
11 eral of the Department of Health and Human Serv-
12 ices, establish a process to monitor compliance with
13 this subsection.

14 “(5) ENFORCEMENT.—

15 “(A) IN GENERAL.—In the case that the
16 Secretary determines that an applicable labora-
17 tory is not in compliance with paragraph (1)—

18 “(i) not later than 30 days after such
19 determination, the Secretary shall notify
20 such laboratory of such determination;

21 “(ii) upon request of the Secretary,
22 such laboratory shall submit to the Sec-
23 retary, not later than 45 days after such
24 request is sent, a corrective action plan to
25 comply with such subsection; and

1 “(iii) if such laboratory continues to
2 fail to comply with such paragraph after
3 the date that is 90 days after such notifi-
4 cation is sent (or, in the case of such a
5 laboratory that has submitted a corrective
6 action plan described in clause(ii) in re-
7 sponse to a request so described, after the
8 date that is 90 days after such submis-
9 sion), the Secretary may impose a civil
10 monetary penalty in an amount not to ex-
11 ceed \$300 for each subsequent day during
12 which such failure to comply is ongoing.

13 “(B) INCREASE AUTHORITY.—In applying
14 this paragraph with respect to violations occur-
15 ring in 2027 or a subsequent year, the Sec-
16 retary may through notice and comment rule-
17 making increase the amount of the civil mone-
18 tary penalty under subparagraph (A)(iii).

19 “(C) APPLICATION OF CERTAIN PROVI-
20 SIONS.—The provisions of section 1128A (other
21 than subsections (a) and (b) of such section)
22 shall apply to a civil monetary penalty imposed
23 under this paragraph in the same manner as
24 such provisions apply to a civil monetary pen-

1 alty imposed under subsection (a) of such sec-
2 tion.

3 “(D) AUTHORITY TO WAIVE OR REDUCE
4 PENALTY.—The Secretary may waive or reduce
5 any penalty otherwise applicable with respect to
6 an applicable laboratory under this paragraph if
7 the Secretary determines that imposition of
8 such penalty would result in a significant hard-
9 ship for such laboratory (such as in the case of
10 an applicable laboratory located in a rural or
11 underserved area where imposition of such pen-
12 alty may result in, or contribute to, a lack of
13 access to care for individuals in such area).

14 “(E) CLARIFICATION OF NONAPPLICA-
15 BILITY OF OTHER ENFORCEMENT PROVI-
16 SIONS.—Notwithstanding any other provision of
17 this title, this subsection shall be the sole means
18 of enforcing the provisions of this section.

19 “(6) DEFINITIONS.—In this subsection:

20 “(A) APPLICABLE LABORATORY.—The
21 term ‘applicable laboratory’ has the meaning
22 given such term in section 414.502, of title 42,
23 Code of Federal Regulations (or any successor
24 regulation).

1 “(B) GROUP HEALTH PLAN; GROUP
2 HEALTH INSURANCE COVERAGE; INDIVIDUAL
3 HEALTH INSURANCE COVERAGE.—The terms
4 ‘group health plan’, ‘group health insurance
5 coverage’, and ‘individual health insurance cov-
6 erage’ have the meaning given such terms in
7 section 2791 of the Public Health Service Act.

8 “(C) SPECIFIED CLINICAL DIAGNOSTIC
9 LABORATORY TEST.—The term ‘specified clin-
10 ical diagnostic laboratory test’ means a clinical
11 diagnostic laboratory test that is included on
12 the list of shoppable services specified by the
13 Centers for Medicare & Medicaid Services pur-
14 suant to section 180.60 of title 45, Code of
15 Federal Regulations (or a successor regulation),
16 other than such a test that is an advanced diag-
17 nostic laboratory test (as defined in section
18 1834A(d)(5)).”.

19 (b) PUBLICATION OF HOSPITAL COMPLIANCE WITH
20 PRICE TRANSPARENCY REQUIREMENTS.—Section 1886 of
21 the Social Security Act (42 U.S.C. 1395ww) is amended
22 by adding at the end the following new subsection:

23 “(u) PUBLICATION OF HOSPITAL COMPLIANCE WITH
24 PRICE TRANSPARENCY REQUIREMENTS.—

1 “(1) IN GENERAL.—Beginning January 1,
2 2026, the Secretary shall, for each hospital with re-
3 spect to which the Secretary has conducted a review
4 of such hospital’s compliance with the provisions of
5 section 1899C(a) and found such hospital non-
6 compliant with such provisions—

7 “(A) indicate such noncompliance on such
8 hospital’s entry on the Hospital Compare inter-
9 net website (or a successor website); and

10 “(B) specify whether such hospital—

11 “(i) submitted a corrective action plan
12 described in subsection (a)(5)(A)(ii) of
13 such section (and, if so, the date such plan
14 was received by the Secretary); or

15 “(ii) was subject to a civil monetary
16 penalty imposed under subsection
17 (a)(5)(B) of such section (and, if so, the
18 date of the imposition of such penalty and
19 the amount of such penalty).

20 “(2) ADDITIONS AND UPDATES.—The Secretary
21 shall update any specification described in subpara-
22 graph (A) or (B) of paragraph (1) with respect to
23 such hospital—

24 “(A) in the case of the specification de-
25 scribed in such paragraph (1)(A), as soon as

1 practicable after sending the notification de-
2 scribed in section 1899C(a)(5)(A)(i); and

3 “(B) in the case of the specification de-
4 scribed in such paragraph (1)(B)(ii), as soon as
5 practicable after the imposition of a civil mone-
6 tary penalty described in such paragraph.”.

7 (c) CONFORMING AMENDMENT.—Section 2718(e) of
8 the Public Health Service Act (42 U.S.C. 300gg–18(e))
9 is amended by adding at the end the following new sen-
10 tence: “The preceding sentence shall not apply beginning
11 January 1, 2026.”.

12 (d) FUNDING.—

13 (1) IN GENERAL.—In addition to funds other-
14 wise available, out of any moneys in the Treasury
15 not otherwise appropriated, there are appropriated
16 \$10,000,000 for fiscal year 2024, to remain avail-
17 able until expended, for purposes of—

18 (A) implementing the amendment made by
19 this subsection (a); and

20 (B) monitoring the compliance of entities
21 with such amendment.

22 (2) REPORT ON EXPENDITURES.—Not later
23 than 5 years after the date of the enactment of this
24 Act, the Secretary of Health and Human Services
25 shall submit to the Committee on Ways and Means

1 and the Committee on Energy and Commerce of the
2 House of Representatives and the Committee on Fi-
3 nance of the Senate a report that—

4 (A) describes activities undertaken funded
5 through funds made available under paragraph
6 (1), including a specification of the amount of
7 such funds expended for each such activity; and

8 (B) identifies all entities with which the
9 Secretary has entered into contracts for pur-
10 poses of implementing the amendment made by
11 this subsection (a), monitoring compliance of
12 entities with such amendment, or providing
13 technical assistance to entities to promote com-
14 pliance with such amendment.

15 (e) IMPLEMENTATION.—

16 (1) ACCESSIBILITY.—In implementing section
17 1899C(a)(2)(A)(ii) of the Social Security Act (as
18 added by subsection (a)), the Secretary of Health
19 and Human Services shall through rulemaking en-
20 sure that information made available pursuant to
21 such amendment by an entity is so made available
22 in plain, easily understandable language and that
23 such entity provides access to such interpretation
24 services, translations, and other assistive services to
25 make such information accessible to individuals with

1 limited English proficiency and individuals with dis-
 2 abilities.

3 (2) TECHNICAL ASSISTANCE.—The Secretary of
 4 Health and Human Services shall, to the extent
 5 practicable, provide technical assistance to entities
 6 making public standard charges and prices (as appli-
 7 cable) pursuant to the amendment made by sub-
 8 section (a).

9 **SEC. 102. PROMOTING GROUP HEALTH PLAN PRICE TRANS-**
 10 **PARENCY.**

11 (a) PRICE TRANSPARENCY REQUIREMENTS.—

12 (1) IRC.—

13 (A) IN GENERAL.—Section 9819 of the In-
 14 ternal Revenue Code of 1986 (26. U.S.C. 9816)
 15 is amended to read as follows:

16 **“SEC. 9819. PRICE TRANSPARENCY REQUIREMENTS.**

17 **“(a) COST SHARING TRANSPARENCY.—**

18 **“(1) IN GENERAL.—**For plan years beginning
 19 on or after the date that is 2 years after the date
 20 of the enactment of the Health Care Price Trans-
 21 parency Act of 2023, a group health plan shall per-
 22 mit individuals to learn the amount of cost-sharing
 23 (including deductibles, copayments, and coinsurance)
 24 under the individual’s plan or coverage that the indi-
 25 vidual would be responsible for paying with respect

1 to the furnishing of a specific item or service by a
2 provider in a timely manner upon the request of the
3 individual. At a minimum, such information shall in-
4 clude the information specified in paragraph (2) and
5 shall be made available to such individual through a
6 self-service tool that meets the requirements of para-
7 graph (3) or, at the option of such individual,
8 through a paper disclosure or phone or other elec-
9 tronic disclosure (as selected by such individual and
10 provided at no cost to such individual) that meets
11 such requirements as the Secretary may specify.

12 “(2) SPECIFIED INFORMATION.—For purposes
13 of paragraph (1), the information specified in this
14 paragraph is, with respect to an item or service for
15 which benefits are available under a group health
16 plan furnished by a health care provider to a partici-
17 pant or beneficiary of such plan, the following:

18 “(A) If such provider is a participating
19 provider with respect to such item or service,
20 the in-network rate (as defined in subsection
21 (c)) for such item or service.

22 “(B) If such provider is not described in
23 subparagraph (A), the maximum allowed
24 amount for such item or service.

1 “(C) The estimated amount of cost sharing
2 (including deductibles, copayments, and coin-
3 surance) that the participant or beneficiary will
4 incur for such item or service (which, in the
5 case such item or service is to be furnished by
6 a provider described in subparagraph (B), shall
7 be calculated using the maximum amount de-
8 scribed in such subparagraph).

9 “(D) The amount the participant or bene-
10 ficiary has already accumulated with respect to
11 any deductible or out of pocket maximum,
12 whether for items and services furnished by a
13 participating provider or for items and services
14 furnished by a provider that is not a partici-
15 pating provider, under the plan (broken down,
16 in the case separate deductibles or maximums
17 apply to separate participants and beneficiaries
18 enrolled in the plan, by such separate
19 deductibles or maximums, in addition to any
20 cumulative deductible or maximum).

21 “(E) In the case such plan imposes any
22 frequency or volume limitations with respect to
23 such item or service (excluding medical neces-
24 sity determinations), the amount that such par-

1 ticipant or beneficiary has accrued towards such
2 limitation with respect to such item or service.

3 “(F) Any prior authorization, concurrent
4 review, step therapy, fail first, or similar re-
5 quirements applicable to coverage of such item
6 or service under such plan.

7 The Secretary may provide that information de-
8 scribed in any of subparagraphs (A) through (F) not
9 be treated as information specified in this para-
10 graph, and specify additional information that shall
11 be treated as information specified in this para-
12 graph, if determined appropriate by the Secretary.

13 “(3) SELF-SERVICE TOOL.—For purposes of
14 paragraph (1), a self-service tool established by a
15 group health plan meets the requirements of this
16 paragraph if such tool—

17 “(A) is based on an Internet website;

18 “(B) provides for real-time responses to re-
19 quests described in paragraph (1);

20 “(C) is updated in a manner such that in-
21 formation provided through such tool is timely
22 and accurate at the time such request is made;

23 “(D) allows such a request to be made
24 with respect to an item or service furnished
25 by—

1 “(i) a specific provider that is a par-
2 ticipating provider with respect to such
3 item or service;

4 “(ii) all providers that are partici-
5 pating providers with respect to such item
6 or service; or

7 “(iii) a provider that is not described
8 in clause (ii);

9 “(E) provides that such a request may be
10 made with respect to an item or service through
11 use of the billing code for such item or service
12 or through use of a descriptive term for such
13 item or service; and

14 “(F) meets any other requirement deter-
15 mined appropriate by the Secretary.

16 The Secretary may require such tool, as a condition
17 of complying with subparagraph (E), to link multiple
18 billing codes to a single descriptive term if the Sec-
19 retary determines that the billing codes to be so
20 linked correspond to similar items and services.

21 “(b) RATE AND PAYMENT INFORMATION.—

22 “(1) IN GENERAL.—For plan years beginning
23 on or after the date that is 2 years after the date
24 of the enactment of the Health Care Price Trans-
25 parency Act of 2023, each group health plan (other

1 than a grandfathered health plan (as defined in sec-
2 tion 1251(e) of the Patient Protection and Afford-
3 able Care Act) shall, not less frequently than once
4 every 3 months (or, in the case of information de-
5 scribed in paragraph (2)(B), not less frequently than
6 monthly), make available to the public the rate and
7 payment information described in paragraph (2) in
8 accordance with paragraph (3).

9 “(2) RATE AND PAYMENT INFORMATION DE-
10 SCRIBED.—For purposes of paragraph (1), the rate
11 and payment information described in this para-
12 graph is, with respect to a group health plan, the
13 following:

14 “(A) With respect to each item or service
15 (other than a drug) for which benefits are avail-
16 able under such plan, the in-network rate in ef-
17 fect with each provider that is a participating
18 provider with respect to such item or service,
19 other than such a rate in effect with a provider
20 that, during the 1-year period ending 10 busi-
21 ness days before the date of the publication of
22 such information, did not submit any claim for
23 such item or service to such plan.

24 “(B) With respect to each drug (identified
25 by national drug code) for which benefits are

1 available under such plan, the average amount
2 paid by such plan (net of rebates, discounts,
3 and price concessions) for such drug dispensed
4 or administered during the 90-day period begin-
5 ning 180 days before such date of publication
6 to each provider that was a participating pro-
7 vider with respect to such drug, broken down by
8 each such provider, other than such an amount
9 paid to a provider that, during such period,
10 submitted fewer than 20 claims for such drug
11 to such plan.

12 “(C) With respect to each item or service
13 for which benefits are available under such
14 plan, the amount billed, and the amount al-
15 lowed by the plan, for each such item or service
16 furnished during the 90-day period specified in
17 subparagraph (B) by a provider that was not a
18 participating provider with respect to such item
19 or service, broken down by each such provider,
20 other than items and services with respect to
21 which fewer than 20 claims for such item or
22 service were submitted to such plan during such
23 period.

24 “(3) MANNER OF PUBLICATION.—Rate and
25 payment information required to be made available

1 under this subsection shall be so made available in
2 dollar amounts through 3 separate machine-readable
3 files (or any successor technology, such as applica-
4 tion program interface technology, determined ap-
5 propriate by the Secretary) corresponding to the in-
6 formation described in each of subparagraphs (A)
7 through (C) of paragraph (2) that meet such re-
8 quirements as specified by the Secretary. Such re-
9 quirements shall ensure that such files are limited to
10 an appropriate size, do not include disclosure of un-
11 necessary duplicative information contained in other
12 files made available under this subsection, are made
13 available in a widely-available format through a pub-
14 licly-available website that allows for information
15 contained in such files to be compared across group
16 health plans, and are accessible to individuals at no
17 cost and without the need to establish a user ac-
18 count or provide other credentials.

19 “(4) USER INSTRUCTIONS.—Each group health
20 plan shall make available to the public instructions
21 written in plain language explaining how individuals
22 may search for information described in paragraph
23 (2) in files submitted in accordance with paragraph
24 (3). The Secretary shall develop and publish a tem-

1 plate that such a plan may use in developing in-
 2 structions for purposes of the preceding sentence.

3 “(5) ATTESTATION.—Each group health plan
 4 shall post, along with rate and payment information
 5 made public by such plan, an attestation that such
 6 information is complete and accurate.

7 “(c) DEFINITIONS.—In this section:

8 “(1) PARTICIPATING PROVIDER.—The term
 9 ‘participating provider’ has the meaning given such
 10 term in section 9816.

11 “(2) IN-NETWORK RATE.—The term ‘in-net-
 12 work rate’ means, with respect to a health plan and
 13 an item or service furnished by a provider that is a
 14 participating provider with respect to such plan and
 15 item or service, the contracted rate in effect between
 16 such plan and such provider for such item or serv-
 17 ice.”.

18 (B) CLERICAL AMENDMENT.—The item re-
 19 lating to section 9819 of the table of sections
 20 for subchapter B of chapter 100 of the Internal
 21 Revenue Code of 1986 is amended to read as
 22 follows:

“Sec. 9819. Price transparency requirements.”.

23 (2) PHSA.—Section 2799A–4 of the Public
 24 Health Service Act (42 U.S.C. 300gg–114) is
 25 amended to read as follows:

1 **“SEC. 2799A-4. PRICE TRANSPARENCY REQUIREMENTS.**

2 “(a) COST SHARING TRANSPARENCY.—

3 “(1) IN GENERAL.—For plan years beginning
4 on or after the date that is 2 years after the date
5 of the enactment of the Health Care Price Trans-
6 parency Act of 2023, a group health plan or a
7 health insurance issuer offering group or individual
8 health insurance coverage shall permit individuals to
9 learn the amount of cost-sharing (including
10 deductibles, copayments, and coinsurance) under the
11 individual’s plan or coverage that the individual
12 would be responsible for paying with respect to the
13 furnishing of a specific item or service by a provider
14 in a timely manner upon the request of the indi-
15 vidual. At a minimum, such information shall in-
16 clude the information specified in paragraph (2) and
17 shall be made available to such individual through a
18 self-service tool that meets the requirements of para-
19 graph (3) or, at the option of such individual,
20 through a paper disclosure or phone or other elec-
21 tronic disclosure (as selected by such individual and
22 provided at no cost to such individual) that meets
23 such requirements as the Secretary may specify.

24 “(2) SPECIFIED INFORMATION.—For purposes
25 of paragraph (1), the information specified in this
26 paragraph is, with respect to an item or service for

1 which benefits are available under a group health
2 plan or group or individual health insurance cov-
3 erage furnished by a health care provider to a par-
4 ticipant or beneficiary of such plan, or enrollee in
5 such coverage, the following:

6 “(A) If such provider is a participating
7 provider with respect to such item or service,
8 the in-network rate (as defined in subsection
9 (c)) for such item or service.

10 “(B) If such provider is not described in
11 subparagraph (A), the maximum allowed
12 amount for such item or service.

13 “(C) The estimated amount of cost sharing
14 (including deductibles, copayments, and coin-
15 surance) that the participant or beneficiary will
16 incur for such item or service (which, in the
17 case such item or service is to be furnished by
18 a provider described in subparagraph (B), shall
19 be calculated using the maximum amount de-
20 scribed in such subparagraph).

21 “(D) The amount the participant, bene-
22 ficiary, or enrollee has already accumulated
23 with respect to any deductible or out of pocket
24 maximum, whether for items and services fur-
25 nished by a participating provider or for items

1 and services furnished by a provider that is not
2 a participating provider, under the plan or cov-
3 erage (broken down, in the case separate
4 deductibles or maximums apply to separate par-
5 ticipants, beneficiaries or enrollees enrolled in
6 the plan or coverage, by such separate
7 deductibles or maximums, in addition to any
8 cumulative deductible or maximum).

9 “(E) In the case such plan or coverage im-
10 poses any frequency or volume limitations with
11 respect to such item or service (excluding med-
12 ical necessity determinations), the amount that
13 such participant, beneficiary, or enrollee has ac-
14 crued towards such limitation with respect to
15 such item or service.

16 “(F) Any prior authorization, concurrent
17 review, step therapy, fail first, or similar re-
18 quirements applicable to coverage of such item
19 or service under such plan or coverage.

20 The Secretary may provide that information de-
21 scribed in any of subparagraphs (A) through (F) not
22 be treated as information specified in this para-
23 graph, and specify additional information that shall
24 be treated as information specified in this para-
25 graph, if determined appropriate by the Secretary.

1 “(3) SELF-SERVICE TOOL.—For purposes of
2 paragraph (1), a self-service tool established by a
3 group health plan or group or individual health in-
4 surance coverage meets the requirements of this
5 paragraph if such tool—

6 “(A) is based on an Internet website;

7 “(B) provides for real-time responses to re-
8 quests described in paragraph (1);

9 “(C) is updated in a manner such that in-
10 formation provided through such tool is timely
11 and accurate at the time such request is made;

12 “(D) allows such a request to be made
13 with respect to an item or service furnished
14 by—

15 “(i) a specific provider that is a par-
16 ticipating provider with respect to such
17 item or service;

18 “(ii) all providers that are partici-
19 pating providers with respect to such item
20 or service; or

21 “(iii) a provider that is not described
22 in clause (ii);

23 “(E) provides that such a request may be
24 made with respect to an item or service through
25 use of the billing code for such item or service

1 or through use of a descriptive term for such
2 item or service; and

3 “(F) meets any other requirement deter-
4 mined appropriate by the Secretary.

5 The Secretary may require such tool, as a condition
6 of complying with subparagraph (E), to link multiple
7 billing codes to a single descriptive term if the Sec-
8 retary determines that the billing codes to be so
9 linked correspond to similar items and services.

10 “(b) RATE AND PAYMENT INFORMATION.—

11 “(1) IN GENERAL.—For plan years beginning
12 on or after the date that is 2 years after the date
13 of the enactment of the Health Care Price Trans-
14 parency Act of 2023, each group health plan (other
15 than a grandfathered health plan (as defined in sec-
16 tion 1251(e) of the Patient Protection and Afford-
17 able Care Act) or group or individual health insur-
18 ance coverage, shall, not less frequently than once
19 every 3 months (or, in the case of information de-
20 scribed in paragraph (2)(B), not less frequently than
21 monthly), make available to the public the rate and
22 payment information described in paragraph (2) in
23 accordance with paragraph (3).

24 “(2) RATE AND PAYMENT INFORMATION DE-
25 SCRIBED.—For purposes of paragraph (1), the rate

1 and payment information described in this para-
2 graph is, with respect to a group health plan or
3 group or individual health insurance coverage, the
4 following:

5 “(A) With respect to each item or service
6 (other than a drug) for which benefits are avail-
7 able under such plan or coverage, the in-net-
8 work rate in effect with each provider that is a
9 participating provider with respect to such item
10 or service, other than such a rate in effect with
11 a provider that, during the 1-year period ending
12 10 business days before the date of the publica-
13 tion of such information, did not submit any
14 claim for such item or service to such plan or
15 coverage.

16 “(B) With respect to each drug (identified
17 by national drug code) for which benefits are
18 available under such plan, the average amount
19 paid by such plan or coverage (net of rebates,
20 discounts, and price concessions) for such drug
21 dispensed or administered during the 90-day
22 period beginning 180 days before such date of
23 publication to each provider that was a partici-
24 pating provider with respect to such drug, bro-
25 ken down by each such provider, other than

1 such an amount paid to a provider that, during
2 such period, submitted fewer than 20 claims for
3 such drug to such plan or coverage.

4 “(C) With respect to each item or service
5 for which benefits are available under such plan
6 or coverage, the amount billed, and the amount
7 allowed by the plan or coverage, for each such
8 item or service furnished during the 90-day pe-
9 riod specified in subparagraph (B) by a pro-
10 vider that was not a participating provider with
11 respect to such item or service, broken down by
12 each such provider, other than items and serv-
13 ices with respect to which fewer than 20 claims
14 for such item or service were submitted to such
15 plan or coverage during such period.

16 “(3) MANNER OF PUBLICATION.—Rate and
17 payment information required to be made available
18 under this subsection shall be so made available in
19 dollar amounts through 3 separate machine-readable
20 files (or any successor technology, such as applica-
21 tion program interface technology, determined ap-
22 propriate by the Secretary) corresponding to the in-
23 formation described in each of subparagraphs (A)
24 through (C) of paragraph (2) that meet such re-
25 quirements as specified by the Secretary. Such re-

1 quirements shall ensure that such files are limited to
2 an appropriate size, do not include disclosure of un-
3 necessary duplicative information contained in other
4 files made available under this subsection, are made
5 available in a widely-available format through a pub-
6 licly-available website that allows for information
7 contained in such files to be compared across group
8 health plans and group and individual health insur-
9 ance coverage, and are accessible to individuals at no
10 cost and without the need to establish a user ac-
11 count or provide other credentials.

12 “(4) USER INSTRUCTIONS.—Each group health
13 plan and group or individual health insurance cov-
14 erage shall make available to the public instructions
15 written in plain language explaining how individuals
16 may search for information described in paragraph
17 (2) in files submitted in accordance with paragraph
18 (3). The Secretary shall develop and publish a tem-
19 plate that such a plan or coverage may use in devel-
20 oping instructions for purposes of the preceding sen-
21 tence.

22 “(5) ATTESTATION.—Each group health plan
23 and group or individual health insurance coverage
24 shall post, along with rate and payment information

1 made public by such plan or coverage, an attestation
 2 that such information is complete and accurate.

3 “(c) DEFINITIONS.—In this section:

4 “(1) PARTICIPATING PROVIDER.—The term
 5 ‘participating provider’ has the meaning given such
 6 term in section 2791A–1(a)(3)(G)(ii).

7 “(2) IN-NETWORK RATE.—The term ‘in-net-
 8 work rate’ means, with respect to a health plan or
 9 coverage and an item or service furnished by a pro-
 10 vider that is a participating provider with respect to
 11 such plan and item or service, the contracted rate in
 12 effect between such plan or coverage and such pro-
 13 vider for such item or service.”.

14 (3) ERISA.—

15 (A) IN GENERAL.—Section 719 of the Em-
 16 ployee Retirement Income Security Act of 1974
 17 (29 U.S.C. 1185h) is amended to read as fol-
 18 lows:

19 **“SEC. 719. PRICE TRANSPARENCY REQUIREMENTS.**

20 “(a) COST SHARING TRANSPARENCY.—

21 “(1) IN GENERAL.—For plan years beginning
 22 on or after the date that is 2 years after the date
 23 of the enactment of the Health Care Price Trans-
 24 parency Act of 2023, a group health plan or a
 25 health insurance issuer offering group health insur-

1 ance coverage shall permit individuals to learn the
2 amount of cost-sharing (including deductibles, co-
3 payments, and coinsurance) under the individual's
4 plan or coverage that the individual would be re-
5 sponsible for paying with respect to the furnishing
6 of a specific item or service by a provider in a timely
7 manner upon the request of the individual. At a
8 minimum, such information shall include the infor-
9 mation specified in paragraph (2) and shall be made
10 available to such individual through a self-service
11 tool that meets the requirements of paragraph (3)
12 or, at the option of such individual, through a paper
13 disclosure or phone or other electronic disclosure (as
14 selected by such individual and provided at no cost
15 to such individual) that meets such requirements as
16 the Secretary may specify.

17 “(2) SPECIFIED INFORMATION.—For purposes
18 of paragraph (1), the information specified in this
19 paragraph is, with respect to an item or service for
20 which benefits are available under a group health
21 plan or group health insurance coverage furnished
22 by a health care provider to a participant or bene-
23 ficiary of such plan, or enrollee in such coverage, the
24 following:

1 “(A) If such provider is a participating
2 provider with respect to such item or service,
3 the in-network rate (as defined in subsection
4 (c)) for such item or service.

5 “(B) If such provider is not described in
6 subparagraph (A), the maximum allowed
7 amount for such item or service.

8 “(C) The estimated amount of cost sharing
9 (including deductibles, copayments, and coin-
10 surance) that the participant or beneficiary will
11 incur for such item or service (which, in the
12 case such item or service is to be furnished by
13 a provider described in subparagraph (B), shall
14 be calculated using the maximum amount de-
15 scribed in such subparagraph).

16 “(D) The amount the participant, bene-
17 ficiary, or enrollee has already accumulated
18 with respect to any deductible or out of pocket
19 maximum, whether for items and services fur-
20 nished by a participating provider or for items
21 and services furnished by a provider that is not
22 a participating provider, under the plan or cov-
23 erage (broken down, in the case separate
24 deductibles or maximums apply to separate par-
25 ticipants, beneficiaries or enrollees enrolled in

1 the plan or coverage, by such separate
2 deductibles or maximums, in addition to any
3 cumulative deductible or maximum).

4 “(E) In the case such plan or coverage im-
5 poses any frequency or volume limitations with
6 respect to such item or service (excluding med-
7 ical necessity determinations), the amount that
8 such participant, beneficiary, or enrollee has ac-
9 crued towards such limitation with respect to
10 such item or service.

11 “(F) Any prior authorization, concurrent
12 review, step therapy, fail first, or similar re-
13 quirements applicable to coverage of such item
14 or service under such plan or coverage.

15 The Secretary may provide that information de-
16 scribed in any of subparagraphs (A) through (F) not
17 be treated as information specified in this para-
18 graph, and specify additional information that shall
19 be treated as information specified in this para-
20 graph, if determined appropriate by the Secretary.

21 “(3) SELF-SERVICE TOOL.—For purposes of
22 paragraph (1), a self-service tool established by a
23 group health plan or group health insurance cov-
24 erage meets the requirements of this paragraph if
25 such tool—

1 “(A) is based on an Internet website;

2 “(B) provides for real-time responses to re-
3 quests described in paragraph (1);

4 “(C) is updated in a manner such that in-
5 formation provided through such tool is timely
6 and accurate at the time such request is made;

7 “(D) allows such a request to be made
8 with respect to an item or service furnished
9 by—

10 “(i) a specific provider that is a par-
11 ticipating provider with respect to such
12 item or service;

13 “(ii) all providers that are partici-
14 pating providers with respect to such item
15 or service; or

16 “(iii) a provider that is not described
17 in clause (ii);

18 “(E) provides that such a request may be
19 made with respect to an item or service through
20 use of the billing code for such item or service
21 or through use of a descriptive term for such
22 item or service; and

23 “(F) meets any other requirement deter-
24 mined appropriate by the Secretary.

1 The Secretary may require such tool, as a condition
2 of complying with subparagraph (E), to link multiple
3 billing codes to a single descriptive term if the Sec-
4 retary determines that the billing codes to be so
5 linked correspond to similar items and services.

6 “(b) RATE AND PAYMENT INFORMATION.—

7 “(1) IN GENERAL.—For plan years beginning
8 on or after the date that is 2 years after the date
9 of the enactment of the Health Care Price Trans-
10 parency Act of 2023, each group health plan (other
11 than a grandfathered health plan (as defined in sec-
12 tion 1251(e) of the Patient Protection and Afford-
13 able Care Act) or group health insurance coverage,
14 shall, not less frequently than once every 3 months
15 (or, in the case of information described in para-
16 graph (2)(B), not less frequently than monthly),
17 make available to the public the rate and payment
18 information described in paragraph (2) in accord-
19 ance with paragraph (3).

20 “(2) RATE AND PAYMENT INFORMATION DE-
21 SCRIBED.—For purposes of paragraph (1), the rate
22 and payment information described in this para-
23 graph is, with respect to a group health plan or
24 group health insurance coverage, the following:

1 “(A) With respect to each item or service
2 (other than a drug) for which benefits are avail-
3 able under such plan or coverage, the in-net-
4 work rate in effect with each provider that is a
5 participating provider with respect to such item
6 or service, other than such a rate in effect with
7 a provider that, during the 1-year period ending
8 10 business days before the date of the publica-
9 tion of such information, did not submit any
10 claim for such item or service to such plan or
11 coverage.

12 “(B) With respect to each drug (identified
13 by national drug code) for which benefits are
14 available under such plan, the average amount
15 paid by such plan or coverage (net of rebates,
16 discounts, and price concessions) for such drug
17 dispensed or administered during the 90-day
18 period beginning 180 days before such date of
19 publication to each provider that was a partici-
20 pating provider with respect to such drug, bro-
21 ken down by each such provider, other than
22 such an amount paid to a provider that, during
23 such period, submitted fewer than 20 claims for
24 such drug to such plan or coverage.

1 “(C) With respect to each item or service
2 for which benefits are available under such plan
3 or coverage, the amount billed, and the amount
4 allowed by the plan or coverage, for each such
5 item or service furnished during the 90-day pe-
6 riod specified in subparagraph (B) by a pro-
7 vider that was not a participating provider with
8 respect to such item or service, broken down by
9 each such provider, other than items and serv-
10 ices with respect to which fewer than 20 claims
11 for such item or service were submitted to such
12 plan or coverage during such period.

13 “(3) MANNER OF PUBLICATION.—Rate and
14 payment information required to be made available
15 under this subsection shall be so made available in
16 dollar amounts through 3 separate machine-readable
17 files (or any successor technology, such as applica-
18 tion program interface technology, determined ap-
19 propriate by the Secretary) corresponding to the in-
20 formation described in each of subparagraphs (A)
21 through (C) of paragraph (2) that meet such re-
22 quirements as specified by the Secretary. Such re-
23 quirements shall ensure that such files are limited to
24 an appropriate size, do not include disclosure of un-
25 necessary duplicative information contained in other

1 files made available under this subsection, are made
2 available in a widely-available format through a pub-
3 licly-available website that allows for information
4 contained in such files to be compared across group
5 health plans and group and individual health insur-
6 ance coverage, and are accessible to individuals at no
7 cost and without the need to establish a user ac-
8 count or provide other credentials.

9 “(4) USER INSTRUCTIONS.—Each group health
10 plan and group health insurance coverage shall make
11 available to the public instructions written in plain
12 language explaining how individuals may search for
13 information described in paragraph (2) in files sub-
14 mitted in accordance with paragraph (3). The Sec-
15 retary shall develop and publish a template that
16 such a plan or coverage may use in developing in-
17 structions for purposes of the preceding sentence.

18 “(5) ATTESTATION.—Each group health plan
19 and group health insurance coverage shall post,
20 along with rate and payment information made pub-
21 lic by such plan or coverage, an attestation that such
22 information is complete and accurate.

23 “(c) DEFINITIONS.—In this section:

1 “(1) PARTICIPATING PROVIDER.—The term
2 ‘participating provider’ has the meaning given such
3 term in section 716(a)(3)(G)(ii).

4 “(2) IN-NETWORK RATE.—The term ‘in-net-
5 work rate’ means, with respect to a health plan or
6 coverage and an item or service furnished by a pro-
7 vider that is a participating provider with respect to
8 such plan and item or service, the contracted rate in
9 effect between such plan or coverage and such pro-
10 vider for such item or service.”.

11 (B) CLERICAL AMENDMENT.—The table of
12 contents in section 1 of the Employee Retire-
13 ment Income Security Act of 1974 is amended
14 by striking the item relating to section 719 and
15 inserting the following new item:

“Sec. 719. Price transparency requirements.”.

16 (b) ACCESSIBILITY THROUGH IMPLEMENTATION.—
17 In implementing the amendments made by subsection (a),
18 the Secretary of the Treasury, the Secretary of Health and
19 Human Services, and the Secretary of Labor shall take
20 reasonable steps to ensure the accessibility of information
21 made available pursuant to such amendments, including
22 reasonable steps to ensure that such information is pro-
23 vided in plain, easily understandable language and that
24 interpretation, translations, and assistive services are pro-
25 vided by group health plans and health insurance issuers

1 offering group or individual health insurance coverage to
 2 make such information accessible to those with limited
 3 English proficiency and those with disabilities.

4 (c) CONTINUED APPLICABILITY OF RULES FOR PRE-
 5 VIOUS YEARS.—Nothing in the amendments made by sub-
 6 section (a) may be construed as affecting the applicability
 7 of the rule entitled “Transparency in Coverage” published
 8 by the Department of the Treasury, the Department of
 9 Labor, and the Department of Health and Human Serv-
 10 ices on November 12, 2020 (85 Fed. Reg. 72158) for any
 11 plan year beginning before the date that is 2 years after
 12 the date of the enactment of this Act.

13 **SEC. 103. OVERSIGHT OF PHARMACY BENEFITS MANAGER**
 14 **SERVICES.**

15 (a) IRC.—

16 (1) IN GENERAL.—Subchapter B of chapter
 17 100 of the Internal Revenue Code of 1986 is amend-
 18 ed by adding at the end the following:

19 **“SEC. 9826. OVERSIGHT OF PHARMACY BENEFITS MAN-**
 20 **AGER SERVICES.**

21 “(a) IN GENERAL.—For plan years beginning on or
 22 after the date that is 3 years after the date of enactment
 23 of this section, a group health plan, or an entity or sub-
 24 sidiary providing pharmacy benefits management services
 25 on behalf of such a plan, shall not enter into a contract

1 with a drug manufacturer, distributor, wholesaler, subcon-
2 tractor, rebate aggregator, or any associated third party
3 that limits the disclosure of information to plan sponsors
4 in such a manner that prevents the plan, or an entity or
5 subsidiary providing pharmacy benefits management serv-
6 ices on behalf of a plan, from making the report described
7 in subsection (b).

8 “(b) ANNUAL REPORT.—

9 “(1) IN GENERAL.—With respect to plan years
10 beginning on or after the date that is 3 years after
11 the date of enactment of this section, for each such
12 plan year, a group health plan, or an entity pro-
13 viding pharmacy benefits management services on
14 behalf of such a plan, shall submit to the plan spon-
15 sor (as defined in section 3(16)(B) of the Employee
16 Retirement Income Security Act of 1974) of such
17 plan a report in a machine-readable format. Each
18 such report shall include, with respect to such plan
19 provided for such plan year—

20 “(A) to the extent feasible, information col-
21 lected from drug manufacturers (or an entity
22 administering copay assistance on behalf of
23 such manufacturers) by such plan (or entity or
24 subsidiary providing pharmacy benefits manage-
25 ment services on behalf of such plan) on the

1 total amount of copayment assistance dollars
2 paid, or copayment cards applied, that were
3 funded by the drug manufacturer with respect
4 to the participants and beneficiaries in such
5 plan;

6 “(B) a list of each drug covered by such
7 plan that was dispensed during the plan year,
8 including, with respect to each such drug dur-
9 ing such plan year—

10 “(i) the brand name, chemical entity,
11 and National Drug Code;

12 “(ii) the number of participants and
13 beneficiaries for whom the drug was dis-
14 pensed during the plan year, the total
15 number of prescription claims for the drug
16 (including original prescriptions and re-
17 fills), and the total number of dosage units
18 of the drug dispensed across the plan year,
19 disaggregated by dispensing channel (such
20 as retail, mail order, or specialty phar-
21 macy);

22 “(iii) the wholesale acquisition cost,
23 listed as cost per days supply and cost per
24 pill, or in the case of a drug in another
25 form, per dosage unit;

1 “(iv) the total out-of-pocket spending
2 by participants and beneficiaries on such
3 drug, including participant and beneficiary
4 spending through copayments, coinsurance,
5 and deductibles;

6 “(v) for any drug for which gross
7 spending of the group health plan exceeded
8 \$10,000 during the plan year—

9 “(I) a list of all other drugs in
10 the same therapeutic category or
11 class, including brand name drugs
12 and biological products and generic
13 drugs or biosimilar biological products
14 that are in the same therapeutic cat-
15 egory or class as such drug; and

16 “(II) the rationale for the for-
17 mulary placement of such drug in that
18 therapeutic category or class, if appli-
19 cable;

20 “(vi) the amount received, or expected
21 to be received, from drug manufacturers in
22 rebates, fees, alternative discounts, or
23 other remuneration for claims incurred for
24 such drug during the plan year;

1 “(vii) the total net spending, after de-
2 ducting rebates, price concessions, alter-
3 native discounts or other remuneration
4 from drug manufacturers, by the health
5 plan on such drug; and

6 “(viii) the net price per course of
7 treatment or single fill, such as a 30-day
8 supply or 90-day supply, incurred by the
9 health plan and its participants and bene-
10 ficiaries after manufacturer rebates, fees,
11 and other remuneration for such drug dis-
12 pensed during the plan year;

13 “(C) a list of each therapeutic category or
14 class of drugs that were dispensed under the
15 health plan during the plan year, and, with re-
16 spect to each such therapeutic category or class
17 of drugs, during the plan year—

18 “(i) total gross spending by the plan,
19 before manufacturer rebates, fees, or other
20 manufacturer remuneration;

21 “(ii) the number of participants and
22 beneficiaries who were dispensed a drug
23 covered by such plan in that category or
24 class, broken down by each such drug
25 (identified by National Drug Code);

1 “(iii) if applicable to that category or
2 class, a description of the formulary tiers
3 and utilization management (such as prior
4 authorization or step therapy) employed
5 for drugs in that category or class; and

6 “(iv) the total out-of-pocket spending
7 by participants and beneficiaries, including
8 participant and beneficiary spending
9 through copayments, coinsurance, and
10 deductibles;

11 “(D) total gross spending on prescription
12 drugs by the plan during the plan year, before
13 rebates and other manufacturer fees or remuneration;
14

15 “(E) total amount received, or expected to
16 be received, by the health plan in drug manufacturer rebates, fees, alternative discounts, and
17 all other remuneration received from the manufacturer or any third party, other than the plan
18 sponsor, related to utilization of drug or drug
19 spending under that health plan during the
20 plan year;
21

22 “(F) the total net spending on prescription
23 drugs by the health plan during the plan year;
24 and
25

1 “(G) amounts paid directly or indirectly in
2 rebates, fees, or any other type of remuneration
3 to brokers, consultants, advisors, or any other
4 individual or firm for the referral of the group
5 health plan’s business to the pharmacy benefits
6 manager.

7 “(2) PRIVACY REQUIREMENTS.—Entities pro-
8 viding pharmacy benefits management services on
9 behalf of a group health plan shall provide informa-
10 tion under paragraph (1) in a manner consistent
11 with the privacy, security, and breach notification
12 regulations promulgated under section 264(c) of the
13 Health Insurance Portability and Accountability Act
14 of 1996, and shall restrict the use and disclosure of
15 such information according to such privacy regula-
16 tions.

17 “(3) DISCLOSURE AND REDISCLOSURE.—

18 “(A) LIMITATION TO BUSINESS ASSOCI-
19 ATES.—A group health plan receiving a report
20 under paragraph (1) may disclose such informa-
21 tion only to business associates of such plan as
22 defined in section 160.103 of title 45, Code of
23 Federal Regulations (or successor regulations).

24 “(B) CLARIFICATION REGARDING PUBLIC
25 DISCLOSURE OF INFORMATION.—Nothing in

1 this section prevents an entity providing phar-
2 macy benefits management services on behalf of
3 a group health plan from placing reasonable re-
4 strictions on the public disclosure of the infor-
5 mation contained in a report described in para-
6 graph (1), except that such entity may not re-
7 strict disclosure of such report to the Depart-
8 ment of Health and Human Services, the De-
9 partment of Labor, the Department of the
10 Treasury, the Comptroller General of the
11 United States, or applicable State agencies.

12 “(C) LIMITED FORM OF REPORT.—The
13 Secretary shall define through rulemaking a
14 limited form of the report under paragraph (1)
15 required of plan sponsors who are drug manu-
16 facturers, drug wholesalers, or other direct par-
17 ticipants in the drug supply chain, in order to
18 prevent anti-competitive behavior.

19 “(4) REPORT TO GAO.—A group health plan, or
20 an entity providing pharmacy benefits management
21 services on behalf of a group health plan, shall sub-
22 mit to the Comptroller General of the United States
23 each of the first 4 reports submitted to a plan spon-
24 sor under paragraph (1) with respect to such plan,
25 and other such reports as requested, in accordance

1 with the privacy requirements under paragraph (2),
 2 the disclosure and redisclosure standards under
 3 paragraph (3), the standards specified pursuant to
 4 paragraph (5), and such other information that the
 5 Comptroller General determines necessary to carry
 6 out the study under section 103(d) of the Health
 7 Care Price Transparency Act of 2023.

8 “(5) STANDARD FORMAT.—Not later than 18
 9 months after the date of enactment of this section,
 10 the Secretary shall specify through rulemaking
 11 standards for entities required to submit reports
 12 under paragraph (4) to submit such reports in a
 13 standard format.

14 “(c) RULE OF CONSTRUCTION.—Nothing in this sec-
 15 tion shall be construed to permit a group health plan or
 16 other entity to restrict disclosure to, or otherwise limit the
 17 access of, the Secretary of the Treasury to a report de-
 18 scribed in subsection (b)(1) or information related to com-
 19 pliance with subsection (a) or (b) by such plan or other
 20 entity subject to such subsections.

21 “(d) DEFINITION.—In this section, the term ‘whole-
 22 sale acquisition cost’ has the meaning given such term in
 23 section 1847A(c)(6)(B) of the Social Security Act.”.

24 (2) CLERICAL AMENDMENT.—The table of sec-
 25 tions for subchapter B of chapter 100 of the Inter-

1 nal Revenue Code of 1986 is amended by adding at
2 the end the following new item:

“Sec. 9826. Oversight of pharmacy benefits manager services.”.

3 (b) PHSA.—Title XXVII of the Public Health Serv-
4 ice Act (42 U.S.C. 300gg et seq.) is amended—

5 (1) in part D (42 U.S.C. 300gg–111 et seq.),
6 by adding at the end the following new section:

7 **“SEC. 2799A–11. OVERSIGHT OF PHARMACY BENEFITS MAN-**
8 **AGER SERVICES.**

9 “(a) IN GENERAL.—For plan years beginning on or
10 after the date that is 3 years after the date of enactment
11 of this section, a group health plan or health insurance
12 issuer offering group health insurance coverage, or an en-
13 tity or subsidiary providing pharmacy benefits manage-
14 ment services on behalf of such a plan or issuer, shall not
15 enter into a contract with a drug manufacturer, dis-
16 tributor, wholesaler, subcontractor, rebate aggregator, or
17 any associated third party that limits the disclosure of in-
18 formation to plan sponsors in such a manner that prevents
19 the plan or issuer, or an entity or subsidiary providing
20 pharmacy benefits management services on behalf of a
21 plan or issuer, from making the report described in sub-
22 section (b).

23 “(b) ANNUAL REPORT.—

24 “(1) IN GENERAL.—With respect to plan years
25 beginning on or after the date that is 3 years after

1 the date of enactment of this section, for each such
2 plan year, a group health plan or health insurance
3 issuer offering group health insurance coverage, or
4 an entity providing pharmacy benefits management
5 services on behalf of such a plan or an issuer, shall
6 submit to the plan sponsor (as defined in section
7 3(16)(B) of the Employee Retirement Income Secu-
8 rity Act of 1974) of such plan or coverage a report
9 in a machine-readable format. Each such report
10 shall include, with respect to such plan or coverage
11 provided for such plan year—

12 “(A) to the extent feasible, information col-
13 lected from drug manufacturers (or an entity
14 administering copay assistance on behalf of
15 such manufacturers) by such plan or issuer (or
16 entity or subsidiary providing pharmacy bene-
17 fits management services on behalf of such plan
18 or issuer) on the total amount of copayment as-
19 sistance dollars paid, or copayment cards ap-
20 plied, that were funded by the drug manufac-
21 turer with respect to the participants, bene-
22 ficiaries, and enrollees in such plan or coverage;

23 “(B) a list of each drug covered by such
24 plan or coverage that was dispensed during the

1 plan year, including, with respect to each such
2 drug during such plan year—

3 “(i) the brand name, chemical entity,
4 and National Drug Code;

5 “(ii) the number of participants, bene-
6 ficiaries, and enrollees for whom the drug
7 was dispensed during the plan year, the
8 total number of prescription claims for the
9 drug (including original prescriptions and
10 refills), and the total number of dosage
11 units of the drug dispensed across the plan
12 year, disaggregated by dispensing channel
13 (such as retail, mail order, or specialty
14 pharmacy);

15 “(iii) the wholesale acquisition cost,
16 listed as cost per days supply and cost per
17 pill, or in the case of a drug in another
18 form, per dosage unit;

19 “(iv) the total out-of-pocket spending
20 by participants, beneficiaries, and enrollees
21 on such drug, including participant, bene-
22 ficiary, and enrollee spending through co-
23 payments, coinsurance, and deductibles;

24 “(v) for any drug for which gross
25 spending of the group health plan or

1 health insurance coverage exceeded
2 \$10,000 during the plan year—

3 “(I) a list of all other drugs in
4 the same therapeutic category or
5 class, including brand name drugs
6 and biological products and generic
7 drugs or biosimilar biological products
8 that are in the same therapeutic cat-
9 egory or class as such drug; and

10 “(II) the rationale for the for-
11 mulary placement of such drug in that
12 therapeutic category or class, if appli-
13 cable;

14 “(vi) the amount received, or expected
15 to be received, from drug manufacturers in
16 rebates, fees, alternative discounts, or
17 other remuneration for claims incurred for
18 such drug during the plan year;

19 “(vii) the total net spending, after de-
20 ducting rebates, price concessions, alter-
21 native discounts or other remuneration
22 from drug manufacturers, by the health
23 plan or health insurance coverage on such
24 drug; and

1 “(viii) the net price per course of
2 treatment or single fill, such as a 30-day
3 supply or 90-day supply, incurred by the
4 health plan or health insurance coverage
5 and its participants, beneficiaries, and en-
6 rollees, after manufacturer rebates, fees,
7 and other remuneration for such drug dis-
8 pensed during the plan year;

9 “(C) a list of each therapeutic category or
10 class of drugs that were dispensed under the
11 health plan or health insurance coverage during
12 the plan year, and, with respect to each such
13 therapeutic category or class of drugs, during
14 the plan year—

15 “(i) total gross spending by the plan
16 or coverage, before manufacturer rebates,
17 fees, or other manufacturer remuneration;

18 “(ii) the number of participants, bene-
19 ficiaries, and enrollees who were dispensed
20 a drug covered by such plan or coverage in
21 that category or class, broken down by
22 each such drug (identified by National
23 Drug Code);

24 “(iii) if applicable to that category or
25 class, a description of the formulary tiers

1 and utilization management (such as prior
2 authorization or step therapy) employed
3 for drugs in that category or class; and

4 “(iv) the total out-of-pocket spending
5 by participants, beneficiaries, and enroll-
6 ees, including participant, beneficiary, and
7 enrollee spending through copayments, co-
8 insurance, and deductibles;

9 “(D) total gross spending on prescription
10 drugs by the plan or coverage during the plan
11 year, before rebates and other manufacturer
12 fees or remuneration;

13 “(E) total amount received, or expected to
14 be received, by the health plan or health insur-
15 ance coverage in drug manufacturer rebates,
16 fees, alternative discounts, and all other remu-
17 nation received from the manufacturer or any
18 third party, other than the plan sponsor, re-
19 lated to utilization of drug or drug spending
20 under that health plan or health insurance cov-
21 erage during the plan year;

22 “(F) the total net spending on prescription
23 drugs by the health plan or health insurance
24 coverage during the plan year; and

1 “(G) amounts paid directly or indirectly in
2 rebates, fees, or any other type of remuneration
3 to brokers, consultants, advisors, or any other
4 individual or firm for the referral of the group
5 health plan’s or health insurance issuer’s busi-
6 ness to the pharmacy benefits manager.

7 “(2) PRIVACY REQUIREMENTS.—Health insur-
8 ance issuers offering group health insurance cov-
9 erage and entities providing pharmacy benefits man-
10 agement services on behalf of a group health plan
11 shall provide information under paragraph (1) in a
12 manner consistent with the privacy, security, and
13 breach notification regulations promulgated under
14 section 264(c) of the Health Insurance Portability
15 and Accountability Act of 1996, and shall restrict
16 the use and disclosure of such information according
17 to such privacy regulations.

18 “(3) DISCLOSURE AND REDISCLOSURE.—

19 “(A) LIMITATION TO BUSINESS ASSOCI-
20 ATES.—A group health plan receiving a report
21 under paragraph (1) may disclose such informa-
22 tion only to business associates of such plan as
23 defined in section 160.103 of title 45, Code of
24 Federal Regulations (or successor regulations).

1 “(B) CLARIFICATION REGARDING PUBLIC
2 DISCLOSURE OF INFORMATION.—Nothing in
3 this section prevents a health insurance issuer
4 offering group health insurance coverage or an
5 entity providing pharmacy benefits management
6 services on behalf of a group health plan from
7 placing reasonable restrictions on the public dis-
8 closure of the information contained in a report
9 described in paragraph (1), except that such
10 issuer or entity may not restrict disclosure of
11 such report to the Department of Health and
12 Human Services, the Department of Labor, the
13 Department of the Treasury, the Comptroller
14 General of the United States, or applicable
15 State agencies.

16 “(C) LIMITED FORM OF REPORT.—The
17 Secretary shall define through rulemaking a
18 limited form of the report under paragraph (1)
19 required of plan sponsors who are drug manu-
20 facturers, drug wholesalers, or other direct par-
21 ticipants in the drug supply chain, in order to
22 prevent anti-competitive behavior.

23 “(4) REPORT TO GAO.—A group health plan or
24 health insurance issuer offering group health insur-
25 ance coverage, or an entity providing pharmacy ben-

1 efits management services on behalf of a group
2 health plan shall submit to the Comptroller General
3 of the United States each of the first 4 reports sub-
4 mitted to a plan sponsor under paragraph (1) with
5 respect to such coverage or plan, and other such re-
6 ports as requested, in accordance with the privacy
7 requirements under paragraph (2), the disclosure
8 and redisclosure standards under paragraph (3), the
9 standards specified pursuant to paragraph (5), and
10 such other information that the Comptroller General
11 determines necessary to carry out the study under
12 section 103(d) of the Health Care Price Trans-
13 parency Act of 2023.

14 “(5) STANDARD FORMAT.—Not later than 18
15 months after the date of enactment of this section,
16 the Secretary shall specify through rulemaking
17 standards for health insurance issuers and entities
18 required to submit reports under paragraph (4) to
19 submit such reports in a standard format.

20 “(c) ENFORCEMENT.—

21 “(1) IN GENERAL.—Notwithstanding section
22 2723, the Secretary, in consultation with the Sec-
23 retary of Labor and the Secretary of the Treasury,
24 shall enforce this section.

1 “(2) FAILURE TO PROVIDE TIMELY INFORMA-
2 TION.—A health insurance issuer or an entity pro-
3 viding pharmacy benefits management services that
4 violates subsection (a) or fails to provide information
5 required under subsection (b) shall be subject to a
6 civil monetary penalty in the amount of \$10,000 for
7 each day during which such violation continues or
8 such information is not disclosed or reported.

9 “(3) FALSE INFORMATION.—A health insurance
10 issuer or entity providing pharmacy benefits man-
11 agement services that knowingly provides false infor-
12 mation under this section shall be subject to a civil
13 money penalty in an amount not to exceed \$100,000
14 for each item of false information. Such civil money
15 penalty shall be in addition to other penalties as
16 may be prescribed by law.

17 “(4) PROCEDURE.—The provisions of section
18 1128A of the Social Security Act, other than sub-
19 section (a) and (b) and the first sentence of sub-
20 section (c)(1) of such section shall apply to civil
21 monetary penalties under this subsection in the
22 same manner as such provisions apply to a penalty
23 or proceeding under section 1128A of the Social Se-
24 curity Act.

1 “(5) WAIVERS.—The Secretary may waive pen-
 2 alties under paragraph (2), or extend the period of
 3 time for compliance with a requirement of this sec-
 4 tion, for an entity in violation of this section that
 5 has made a good-faith effort to comply with this sec-
 6 tion.

7 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
 8 tion shall be construed to permit a health insurance issuer,
 9 group health plan, or other entity to restrict disclosure to,
 10 or otherwise limit the access of, the Secretary of Health
 11 and Human Services to a report described in subsection
 12 (b)(1) or information related to compliance with sub-
 13 section (a) or (b) by such issuer, plan, or other entity sub-
 14 ject to such subsections.

15 “(e) DEFINITION.—In this section, the term ‘whole-
 16 sale acquisition cost’ has the meaning given such term in
 17 section 1847A(c)(6)(B) of the Social Security Act.”; and

18 (2) in section 2723 of such Act (42 U.S.C.
 19 300gg-22)—

20 (A) in subsection (a)—

21 (i) in paragraph (1), by inserting
 22 “(other than subsections (a) and (b) of
 23 section 2799A-11)” after “part D”; and

1 (ii) in paragraph (2), by inserting
 2 “(other than subsections (a) and (b) of
 3 section 2799A–11)” after “part D”; and
 4 (B) in subsection (b)—

5 (i) in paragraph (1), by inserting
 6 “(other than subsections (a) and (b) of
 7 section 2799A–11)” after “part D”;

8 (ii) in paragraph (2)(A), by inserting
 9 “(other than subsections (a) and (b) of
 10 section 2799A–11)” after “part D”; and

11 (iii) in paragraph (2)(C)(ii), by insert-
 12 ing “(other than subsections (a) and (b) of
 13 section 2799A–11)” after “part D”.

14 (c) ERISA.—

15 (1) IN GENERAL.—Subtitle B of title I of the
 16 Employee Retirement Income Security Act of 1974
 17 (29 U.S.C. 1021 et seq.) is amended—

18 (A) in subpart B of part 7 (29 U.S.C.
 19 1185 et seq.), by adding at the end the fol-
 20 lowing:

21 **“SEC. 726. OVERSIGHT OF PHARMACY BENEFITS MANAGER**
 22 **SERVICES.**

23 “(a) IN GENERAL.—For plan years beginning on or
 24 after the date that is 3 years after the date of enactment
 25 of this section, a group health plan or health insurance

1 issuer offering group health insurance coverage, or an en-
2 tity or subsidiary providing pharmacy benefits manage-
3 ment services on behalf of such a plan or issuer, shall not
4 enter into a contract with a drug manufacturer, dis-
5 tributor, wholesaler, subcontractor, rebate aggregator, or
6 any associated third party that limits the disclosure of in-
7 formation to plan sponsors in such a manner that prevents
8 the plan or issuer, or an entity or subsidiary providing
9 pharmacy benefits management services on behalf of a
10 plan or issuer, from making the report described in sub-
11 section (b).

12 “(b) ANNUAL REPORT.—

13 “(1) IN GENERAL.—With respect to plan years
14 beginning on or after the date that is 3 years after
15 the date of enactment of this section, for each such
16 plan year, a group health plan or health insurance
17 issuer offering group health insurance coverage, or
18 an entity providing pharmacy benefits management
19 services on behalf of such a plan or an issuer, shall
20 submit to the plan sponsor (as defined in section
21 3(16)(B)) of such plan or coverage a report in a ma-
22 chine-readable format. Each such report shall in-
23 clude, with respect to such plan or coverage provided
24 for such plan year—

1 “(A) to the extent feasible, information col-
2 lected from drug manufacturers (or an entity
3 administering copay assistance on behalf of
4 such manufacturers) by such plan or issuer (or
5 entity or subsidiary providing pharmacy bene-
6 fits management services on behalf of such plan
7 or issuer) on the total amount of copayment as-
8 sistance dollars paid, or copayment cards ap-
9 plied, that were funded by the drug manufac-
10 turer with respect to the participants, bene-
11 ficiaries, and enrollees in such plan or coverage;

12 “(B) a list of each drug covered by such
13 plan or coverage that was dispensed during the
14 plan year, including, with respect to each such
15 drug during such plan year—

16 “(i) the brand name, chemical entity,
17 and National Drug Code;

18 “(ii) the number of participants, bene-
19 ficiaries, and enrollees for whom the drug
20 was dispensed during the plan year, the
21 total number of prescription claims for the
22 drug (including original prescriptions and
23 refills), and the total number of dosage
24 units of the drug dispensed across the plan
25 year, disaggregated by dispensing channel

1 (such as retail, mail order, or specialty
2 pharmacy);

3 “(iii) the wholesale acquisition cost,
4 listed as cost per days supply and cost per
5 pill, or in the case of a drug in another
6 form, per dosage unit;

7 “(iv) the total out-of-pocket spending
8 by participants, beneficiaries, and enrollees
9 on such drug, including participant, bene-
10 ficiary, and enrollee spending through co-
11 payments, coinsurance, and deductibles;

12 “(v) for any drug for which gross
13 spending of the group health plan or
14 health insurance coverage exceeded
15 \$10,000 during the plan year—

16 “(I) a list of all other drugs in
17 the same therapeutic category or
18 class, including brand name drugs
19 and biological products and generic
20 drugs or biosimilar biological products
21 that are in the same therapeutic cat-
22 egory or class as such drug; and

23 “(II) the rationale for the for-
24 mulary placement of such drug in that

1 therapeutic category or class, if appli-
2 cable;

3 “(vi) the amount received, or expected
4 to be received, from drug manufacturers in
5 rebates, fees, alternative discounts, or
6 other remuneration for claims incurred for
7 such drug during the plan year;

8 “(vii) the total net spending, after de-
9 ducting rebates, price concessions, alter-
10 native discounts or other remuneration
11 from drug manufacturers, by the health
12 plan or health insurance coverage on such
13 drug; and

14 “(viii) the net price per course of
15 treatment or single fill, such as a 30-day
16 supply or 90-day supply, incurred by the
17 health plan or health insurance coverage
18 and its participants, beneficiaries, and en-
19 rollees, after manufacturer rebates, fees,
20 and other remuneration for such drug dis-
21 pensed during the plan year;

22 “(C) a list of each therapeutic category or
23 class of drugs that were dispensed under the
24 health plan or health insurance coverage during
25 the plan year, and, with respect to each such

1 therapeutic category or class of drugs, during
2 the plan year—

3 “(i) total gross spending by the plan
4 or coverage, before manufacturer rebates,
5 fees, or other manufacturer remuneration;

6 “(ii) the number of participants, bene-
7 ficiaries, and enrollees who were dispensed
8 a drug covered by such plan or coverage in
9 that category or class, broken down by
10 each such drug (identified by National
11 Drug Code);

12 “(iii) if applicable to that category or
13 class, a description of the formulary tiers
14 and utilization management (such as prior
15 authorization or step therapy) employed
16 for drugs in that category or class; and

17 “(iv) the total out-of-pocket spending
18 by participants, beneficiaries, and enroll-
19 ees, including participant, beneficiary, and
20 enrollee spending through copayments, co-
21 insurance, and deductibles;

22 “(D) total gross spending on prescription
23 drugs by the plan or coverage during the plan
24 year, before rebates and other manufacturer
25 fees or remuneration;

1 “(E) total amount received, or expected to
2 be received, by the health plan or health insur-
3 ance coverage in drug manufacturer rebates,
4 fees, alternative discounts, and all other remun-
5 eration received from the manufacturer or any
6 third party, other than the plan sponsor, re-
7 lated to utilization of drug or drug spending
8 under that health plan or health insurance cov-
9 erage during the plan year;

10 “(F) the total net spending on prescription
11 drugs by the health plan or health insurance
12 coverage during the plan year; and

13 “(G) amounts paid directly or indirectly in
14 rebates, fees, or any other type of remuneration
15 to brokers, consultants, advisors, or any other
16 individual or firm for the referral of the group
17 health plan’s or health insurance issuer’s busi-
18 ness to the pharmacy benefits manager.

19 “(2) PRIVACY REQUIREMENTS.—Health insur-
20 ance issuers offering group health insurance cov-
21 erage and entities providing pharmacy benefits man-
22 agement services on behalf of a group health plan
23 shall provide information under paragraph (1) in a
24 manner consistent with the privacy, security, and
25 breach notification regulations promulgated under

1 section 264(c) of the Health Insurance Portability
2 and Accountability Act of 1996, and shall restrict
3 the use and disclosure of such information according
4 to such privacy regulations.

5 “(3) DISCLOSURE AND REDISCLOSURE.—

6 “(A) LIMITATION TO BUSINESS ASSOCI-
7 ATES.—A group health plan receiving a report
8 under paragraph (1) may disclose such informa-
9 tion only to business associates of such plan as
10 defined in section 160.103 of title 45, Code of
11 Federal Regulations (or successor regulations).

12 “(B) CLARIFICATION REGARDING PUBLIC
13 DISCLOSURE OF INFORMATION.—Nothing in
14 this section prevents a health insurance issuer
15 offering group health insurance coverage or an
16 entity providing pharmacy benefits management
17 services on behalf of a group health plan from
18 placing reasonable restrictions on the public dis-
19 closure of the information contained in a report
20 described in paragraph (1), except that such
21 issuer or entity may not restrict disclosure of
22 such report to the Department of Health and
23 Human Services, the Department of Labor, the
24 Department of the Treasury, the Comptroller

1 General of the United States, or applicable
2 State agencies.

3 “(C) LIMITED FORM OF REPORT.—The
4 Secretary shall define through rulemaking a
5 limited form of the report under paragraph (1)
6 required of plan sponsors who are drug manu-
7 facturers, drug wholesalers, or other direct par-
8 ticipants in the drug supply chain, in order to
9 prevent anti-competitive behavior.

10 “(4) REPORT TO GAO.—A group health plan or
11 health insurance issuer offering group health insur-
12 ance coverage, or an entity providing pharmacy ben-
13 efits management services on behalf of a group
14 health plan shall submit to the Comptroller General
15 of the United States each of the first 4 reports sub-
16 mitted to a plan sponsor under paragraph (1) with
17 respect to such coverage or plan, and other such re-
18 ports as requested, in accordance with the privacy
19 requirements under paragraph (2), the disclosure
20 and redisclosure standards under paragraph (3), the
21 standards specified pursuant to paragraph (5), and
22 such other information that the Comptroller General
23 determines necessary to carry out the study under
24 section 103(d) of the Health Care Price Trans-
25 parency Act of 2023.

1 “(5) STANDARD FORMAT.—Not later than 18
2 months after the date of enactment of this section,
3 the Secretary shall specify through rulemaking
4 standards for health insurance issuers and entities
5 required to submit reports under paragraph (4) to
6 submit such reports in a standard format.

7 “(c) ENFORCEMENT.—

8 “(1) IN GENERAL.—Notwithstanding section
9 502, the Secretary, in consultation with the Sec-
10 retary of Health and Human Services and the Sec-
11 retary of the Treasury, shall enforce this section.

12 “(2) FAILURE TO PROVIDE TIMELY INFORMA-
13 TION.—A health insurance issuer or an entity pro-
14 viding pharmacy benefits management services that
15 violates subsection (a) or fails to provide information
16 required under subsection (b) shall be subject to a
17 civil monetary penalty in the amount of \$10,000 for
18 each day during which such violation continues or
19 such information is not disclosed or reported.

20 “(3) FALSE INFORMATION.—A health insurance
21 issuer or entity providing pharmacy benefits man-
22 agement services that knowingly provides false infor-
23 mation under this section shall be subject to a civil
24 money penalty in an amount not to exceed \$100,000
25 for each item of false information. Such civil money

1 penalty shall be in addition to other penalties as
2 may be prescribed by law.

3 “(4) PROCEDURE.—The provisions of section
4 1128A of the Social Security Act, other than sub-
5 section (a) and (b) and the first sentence of sub-
6 section (c)(1) of such section shall apply to civil
7 monetary penalties under this subsection in the
8 same manner as such provisions apply to a penalty
9 or proceeding under section 1128A of the Social Se-
10 curity Act.

11 “(5) WAIVERS.—The Secretary may waive pen-
12 alties under paragraph (2), or extend the period of
13 time for compliance with a requirement of this sec-
14 tion, for an entity in violation of this section that
15 has made a good-faith effort to comply with this sec-
16 tion.

17 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
18 tion shall be construed to permit a health insurance issuer,
19 group health plan, or other entity to restrict disclosure to,
20 or otherwise limit the access of, the Secretary of Labor
21 to a report described in subsection (b)(1) or information
22 related to compliance with subsection (a) or (b) by such
23 issuer, plan, or other entity subject to such subsections.

1 “(e) DEFINITION.—In this section, the term ‘whole-
2 sale acquisition cost’ has the meaning given such term in
3 section 1847A(c)(6)(B) of the Social Security Act.”; and

4 (B) in section 502 (29 U.S.C. 1132)—

5 (i) in subsection (a)—

6 (I) in paragraph (6), by striking
7 “or (9)” and inserting “(9), or (13)”;

8 (II) in paragraph (10), by strik-
9 ing at the end “or”;

10 (III) in paragraph (11), at the
11 end by striking the period and insert-
12 ing “; or”; and

13 (IV) by adding at the end the fol-
14 lowing new paragraph:

15 “(12) by the Secretary, in consultation with the
16 Secretary of Health and Human Services, and the
17 Secretary of the Treasury, to enforce section 726.”;

18 (ii) in subsection (b)(3), by inserting
19 “and subsections (a)(12) and (c)(13)” be-
20 fore “, the Secretary is not”; and

21 (iii) in subsection (c), by adding at
22 the end the following new paragraph:

23 “(13) SECRETARIAL ENFORCEMENT AUTHORITY
24 RELATING TO OVERSIGHT OF PHARMACY BENEFITS
25 MANAGER SERVICES.—

1 “(A) FAILURE TO PROVIDE TIMELY INFOR-
2 MATION.—The Secretary, in consultation with
3 the Secretary of Health and Human Services
4 and the Secretary of the Treasury, may impose
5 a penalty against any group health plan or
6 health insurance issuer offering group health
7 insurance coverage, or entity providing phar-
8 macy benefits management services on behalf of
9 such plan or coverage, that violates section
10 726(a) or fails to provide information required
11 under section 726(b), in the amount of \$10,000
12 for each day during which such violation con-
13 tinues or such information is not disclosed or
14 reported.

15 “(B) FALSE INFORMATION.—The Sec-
16 retary, in consultation with the Secretary of
17 Health and Human Services and the Secretary
18 of the Treasury, may impose a penalty against
19 a group health plan or health insurance issuer
20 offering group health coverage, or an entity
21 providing pharmacy benefits management serv-
22 ices on behalf of such plan or coverage, that
23 knowingly provides false information under sec-
24 tion 726 in an amount not to exceed \$100,000
25 for each item of false information. Such penalty

1 shall be in addition to other penalties as may
 2 be prescribed by law.

3 “(C) WAIVERS.—The Secretary may waive
 4 penalties under subparagraph (A), or extend
 5 the period of time for compliance with a re-
 6 quirement of section 726, for an entity in viola-
 7 tion of such section that has made a good-faith
 8 effort to comply with such section.”.

9 (2) CLERICAL AMENDMENT.—The table of con-
 10 tents in section 1 of the Employee Retirement In-
 11 come Security Act of 1974 (29 U.S.C. 1001 et seq.)
 12 is amended by inserting after the item relating to
 13 section 725 the following new item:

“Sec. 726. Oversight of pharmacy benefits manager services.”.

14 (d) GAO STUDY.—

15 (1) IN GENERAL.—Not later than 3 years after
 16 the date of enactment of this Act, the Comptroller
 17 General of the United States shall submit to Con-
 18 gress a report on—

19 (A) pharmacy networks of group health
 20 plans, health insurance issuers, and entities
 21 providing pharmacy benefits management serv-
 22 ices under such group health plan or group or
 23 individual health insurance coverage, including
 24 networks that have pharmacies that are under
 25 common ownership (in whole or part) with

1 group health plans, health insurance issuers, or
2 entities providing pharmacy benefits manage-
3 ment services or pharmacy benefits administra-
4 tive services under group health plan or group
5 or individual health insurance coverage;

6 (B) as it relates to pharmacy networks
7 that include pharmacies under common owner-
8 ship described in subparagraph (A)—

9 (i) whether such networks are de-
10 signed to encourage enrollees of a plan or
11 coverage to use such pharmacies over other
12 network pharmacies for specific services or
13 drugs, and if so, the reasons the networks
14 give for encouraging use of such phar-
15 macies; and

16 (ii) whether such pharmacies are used
17 by enrollees disproportionately more in the
18 aggregate or for specific services or drugs
19 compared to other network pharmacies;

20 (C) whether group health plans and health
21 insurance issuers offering group or individual
22 health insurance coverage have options to elect
23 different network pricing arrangements in the
24 marketplace with entities that provide phar-
25 macy benefits management services, the preva-

1 lence of electing such different network pricing
2 arrangements;

3 (D) pharmacy network design parameters
4 that encourage enrollees in the plan or coverage
5 to fill prescriptions at mail order, specialty, or
6 retail pharmacies that are wholly or partially-
7 owned by that issuer or entity; and

8 (E) the degree to which mail order, spe-
9 cialty, or retail pharmacies that dispense pre-
10 scription drugs to an enrollee in a group health
11 plan or health insurance coverage that are
12 under common ownership (in whole or part)
13 with group health plans, health insurance
14 issuers, or entities providing pharmacy benefits
15 management services or pharmacy benefits ad-
16 ministrative services under group health plan or
17 group or individual health insurance coverage
18 receive reimbursement that is greater than the
19 median price charged to the group health plan
20 or health insurance issuer when the same drug
21 is dispensed to enrollees in the plan or coverage
22 by other pharmacies included in the pharmacy
23 network of that plan, issuer, or entity that are
24 not wholly or partially owned by the health in-

1 insurance issuer or entity providing pharmacy
2 benefits management services.

3 (2) REQUIREMENT.—The Comptroller General
4 of the United States shall ensure that the report
5 under paragraph (1) does not contain information
6 that would allow a reader to identify a specific plan
7 or entity providing pharmacy benefits management
8 services or otherwise contain commercial or financial
9 information that is privileged or confidential.

10 (3) DEFINITIONS.—In this subsection, the
11 terms “group health plan”, “health insurance cov-
12 erage”, and “health insurance issuer” have the
13 meanings given such terms in section 2791 of the
14 Public Health Service Act (42 U.S.C. 300gg–91).

15 **SEC. 104. REPORTS ON HEALTH CARE TRANSPARENCY**
16 **TOOLS AND DATA REQUIREMENTS.**

17 (a) INITIAL REPORT.—Not later than December 31,
18 2024, the Comptroller General of the United States shall
19 submit to the Committees (as defined in subsection (d))
20 an initial report that—

21 (1) identifies and describes health care trans-
22 parency tools and Federal health care reporting re-
23 quirements (as described in subsection (d)) that are
24 in effect as of the date of the submission of such ini-
25 tial report, including the frequency of reports with

1 respect to each such requirement and whether any
2 such requirements are duplicative;

3 (2) reviews how such reporting requirements
4 are enforced;

5 (3) analyzes whether the public availability of
6 health care transparency tools, and the publication
7 of data pursuant to such reporting requirements,
8 has—

9 (A) been utilized and valued by consumers,
10 including reasons for such utilization (or lack
11 thereof); and

12 (B) assisted health insurance plan spon-
13 sors and fiduciaries improve benefits, lower
14 health care costs for plan participants, and
15 meet fiduciary requirements;

16 (4) includes recommendations to the Commit-
17 tees, the Secretary of Health and Human Services,
18 the Secretary of Labor, and the Secretary of the
19 Treasury to—

20 (A) improve the efficiency, accuracy, and
21 usability of health care transparency tools;

22 (B) streamline Federal health care report-
23 ing requirements to eliminate duplicative re-
24 quirements and reduce the burden on entities

1 required to submit reports pursuant to such
2 provisions;

3 (C) improve the accuracy and efficiency of
4 such reports while maintaining the integrity
5 and usability of the data provided by such re-
6 ports;

7 (D) address any gaps in data provided by
8 such reports; and

9 (E) ensure that the data and information
10 reported is comparable and usable to con-
11 sumers, including patients, plan sponsors, and
12 policy makers.

13 (b) FINAL REPORT.—Not later than December 31,
14 2028, the Comptroller General of the United States shall
15 submit to the Committees a report that includes—

16 (1) the information provided in the initial re-
17 port, along with any updates to such information;
18 and

19 (2) any new information with respect to health
20 care transparency tools that have been released fol-
21 lowing the submission of such initial report, or new
22 reporting requirements in effect as of the date of the
23 submission of the final report.

24 (c) REPORT ON EXPANDING PRICE TRANSPARENCY
25 REQUIREMENTS.—Not later than December 31, 2025, the

1 Comptroller General of the United States, in consultation
2 with the Secretary of Health and Human Services, health
3 care provider groups, and patient advocacy groups, shall
4 submit to the Committees a report that includes rec-
5 ommendations to expand price transparency reporting re-
6 quirements to additional care settings, with an emphasis
7 on settings where shoppable services (as defined in sub-
8 section (d)) are furnished.

9 (d) DEFINITIONS.—In this section:

10 (1) COMMITTEES.—The term “Committees”
11 means the Committee on Ways and Means, the
12 Committee on Energy and Commerce, and the Com-
13 mittee on Education and the Workforce of the
14 House of Representatives, and the Committee on Fi-
15 nance and the Committee on Health, Education,
16 Labor, and Pensions of the Senate.

17 (2) FEDERAL HEALTH CARE REPORTING RE-
18 QUIREMENTS.—The term “Federal health care re-
19 porting requirements” includes regulatory and statu-
20 tory requirements with respect to the reporting and
21 publication of health care price, cost access, and
22 quality data, including requirements established by
23 the Consolidated Appropriations Act of 2021 (Public
24 Law 116–260), this Act, and other reporting and
25 publication requirements with respect to trans-

1 parency in health care as identified by the Comp-
2 troller General of the United States.

3 (3) SHOPPABLE SERVICE.—The term
4 “shoppable service” means a service that can be
5 scheduled by a health care consumer in advance and
6 includes all ancillary items and services customarily
7 furnished as part of such service.

8 **SEC. 105. REPORT ON INTEGRATION IN MEDICARE.**

9 (a) REQUIRED MA AND PDP REPORTING.—

10 (1) MA PLANS.—Section 1857(e) of the Social
11 Security Act (42 U.S.C. 1395w–27(e)) is amended
12 by adding at the end the following new paragraph:

13 “(6) REQUIRED DISCLOSURE OF CERTAIN IN-
14 FORMATION RELATING TO HEALTH CARE PROVIDER
15 OWNERSHIP.—

16 “(A) IN GENERAL.—For plan year 2025
17 and for every third plan year thereafter, each
18 MA organization offering an MA plan under
19 this part during such plan year shall submit to
20 the Secretary, at a time and in a manner speci-
21 fied by the Secretary—

22 “(i) the taxpayer identification num-
23 ber for each health care provider that was
24 a specified health care provider with re-

1 spect to such organization during such
2 year;

3 “(ii) the total amount of incentive-
4 based payments made to, and the total
5 amount of shared losses recoupments col-
6 lected from, such specified health care pro-
7 viders during such plan year; and

8 “(iii) the total amount of incentive-
9 based payments made to, and the total
10 amount of shared losses recoupments col-
11 lected from, providers of services and sup-
12 pliers not described in clause (ii) during
13 such plan year.

14 “(B) DEFINITION.—For purposes of this
15 paragraph, the term ‘specified health care pro-
16 vider’ means, with respect to an MA organiza-
17 tion and a plan year, a provider of services or
18 supplier with respect to which such organization
19 (or any person with an ownership or control in-
20 terest (as defined in section 1124(a)(3)) in such
21 organization) is a person with an ownership or
22 control interest (as so defined).”.

23 (2) PRESCRIPTION DRUG PLANS.—Section
24 1860D–12(b) of the Social Security Act (42 U.S.C.

1 1395w–112(b)) is amended by adding at the end the
2 following new paragraph:

3 “(9) PROVISION OF INFORMATION RELATING TO
4 PHARMACY OWNERSHIP.—

5 “(A) IN GENERAL.—For plan year 2025
6 and for every third plan year thereafter, each
7 PDP sponsor offering a prescription drug plan
8 under this part during such plan year shall sub-
9 mit to the Secretary, at a time and in a manner
10 specified by the Secretary, the taxpayer identi-
11 fication number and National Provider Identifi-
12 fier for each pharmacy that was a specified
13 pharmacy with respect to such sponsor during
14 such year.

15 “(B) DEFINITION.—For purposes of this
16 paragraph, the term ‘specified pharmacy’
17 means, with respect to an PDP sponsor offering
18 a prescription drug plan and a plan year, a
19 pharmacy with respect to which—

20 “(i) such sponsor (or any person with
21 an ownership or control interest (as de-
22 fined in section 1124(a)(3)) in such spon-
23 sor) is a person with an ownership or con-
24 trol interest (as so defined); or

1 “(ii) a pharmacy benefit manager of-
2 fering services under such plan (or any
3 person with an ownership or control inter-
4 est (as so defined) in such sponsor) is a
5 person with an ownership or control inter-
6 est (as so defined).”.

7 (b) MEDPAC REPORTS.—Part E of title XVIII of the
8 Social Security Act (42 U.S.C. 1395x et seq.), as amended
9 by section 101, is further amended by adding at the end
10 the following new section:

11 **“SEC. 1899D. REPORTS ON VERTICAL INTEGRATION UNDER**
12 **MEDICARE.**

13 “(a) IN GENERAL.—Not later than June 15, 2029,
14 and every 3 years thereafter, the Medicare Payment Advi-
15 sory Commission shall submit to Congress a report on the
16 state of vertical integration in the health care sector dur-
17 ing the applicable year with respect to entities partici-
18 pating in the Medicare program, including health care pro-
19 viders, pharmacies, prescription drug plan sponsors, Medi-
20 care Advantage organizations, and pharmacy benefit man-
21 agers. Such report shall include—

22 “(1) with respect to Medicare Advantage orga-
23 nizations, the evaluation described in subsection (b);

24 “(2) with respect to prescription drug plans,
25 pharmacy benefit managers, and pharmacies, the

1 comparisons and evaluations described in subsection
2 (c);

3 “(3) with respect to Medicare Advantage plans
4 under which benefits are available for physician-ad-
5 ministered drugs, the information described in sub-
6 section (d); and

7 “(4) the identifications described in subsection
8 (e); and

9 “(5) an analysis of the impact of such integra-
10 tion on health care access, price, quality, and out-
11 comes.

12 “(b) MEDICARE ADVANTAGE ORGANIZATIONS.—For
13 purposes of subsection (a)(1), the evaluation described in
14 this subsection is, with respect to Medicare Advantage or-
15 ganizations and an applicable year, an evaluation, taking
16 into account patient acuity and the types of areas serviced
17 by such organization, of—

18 “(1) the average number of qualifying diag-
19 noses made during such year with respect to enroll-
20 ees of a Medicare Advantage plan offered by such
21 organization who, during such year, received a
22 health risk assessment from a specified health care
23 provider;

24 “(2) the average risk score for such enrollees
25 who received such an assessment during such year;

1 “(3) any relationship between such risk scores
2 for such enrollees receiving such an assessment from
3 such a provider during such year and incentive pay-
4 ments made to such providers;

5 “(4) the average risk score for enrollees of such
6 plan who received any item or service from a speci-
7 fied health care provider during such year;

8 “(5) any relationship between the risk scores of
9 enrollees under such plan and whether the enrollees
10 have received any item or service from a specified
11 provider; and

12 “(6) any relationship between the risk scores of
13 enrollees under such plan that have received any
14 item or service from a specified provider and incen-
15 tive payments made under the plan to specified pro-
16 viders.

17 “(c) PRESCRIPTION DRUG PLANS.—For purposes of
18 subsection (a)(2), the comparisons and evaluations de-
19 scribed in this subsection are, with respect to prescription
20 drug plans and an applicable year, the following:

21 “(1) For each covered part D drug for which
22 benefits are available under such a plan, a compari-
23 son of the average negotiated rate in effect with
24 specified pharmacies with such rates in effect for in-

1 network pharmacies that are not specified phar-
2 macies.

3 “(2) Comparisons of the following:

4 “(A) The total amount paid by pharmacy
5 benefit managers to specified pharmacies for
6 covered part D drugs and the total amount so
7 paid to pharmacies that are not specified phar-
8 macies for such drugs.

9 “(B) The total amount paid by such spon-
10 sors to specified pharmacy benefit managers as
11 reimbursement for covered part D drugs and
12 the total amount so paid to pharmacy benefit
13 managers that are not specified pharmacy ben-
14 efit managers as such reimbursement.

15 “(C) Fees paid under by plan to specified
16 pharmacy benefit managers compared to such
17 fees paid to pharmacy benefit managers that
18 are not specified pharmacy benefit managers.

19 “(3) An evaluation of the total amount of direct
20 and indirect remuneration for covered part D drugs
21 passed through to prescription drug plan sponsors
22 and the total amount retained by pharmacy benefit
23 managers (including entities under contract with
24 such a manager).

1 “(4) To the extent that the available data per-
2 mits, an evaluation of fees charged by rebate
3 aggregators that are affiliated with plan sponsors.

4 “(d) PHYSICIAN-ADMINISTERED DRUGS.—For pur-
5 poses of subsection (a)(3), the information described in
6 this subsection is, with respect to physician-administered
7 drugs for which benefits are available under a Medicare
8 Advantage plan during an applicable year, the following:

9 “(1) With respect to each such plan, an identi-
10 fication of each drug for which benefits were avail-
11 able under such plan only when administered by a
12 health care provider that acquired such drug from
13 an affiliated pharmacy.

14 “(2) An evaluation of the difference between
15 the total number of drugs administered by a health
16 care provider that were acquired from affiliated
17 pharmacies compared to the number of such drugs
18 so administered that were acquired from pharmacies
19 other than affiliated pharmacies, and an evaluation
20 of the difference in payments for such drugs so ad-
21 ministered when acquired from a specified pharmacy
22 and when acquired from a pharmacy that is not a
23 specified pharmacy.

24 “(3) An evaluation of the dollar value of all
25 such drugs that were not so administered because of

1 a delay attributable to an affiliated pharmacy com-
2 pared to the dollar value of all such drugs that were
3 not so administered because of a delay attributable
4 to pharmacy that is not an affiliated pharmacy.

5 “(4) The number of enrollees administered such
6 a drug that was acquired from an affiliated phar-
7 macy.

8 “(5) The number of enrollees furnished such a
9 drug that was acquired from a pharmacy that is not
10 an affiliated pharmacy.

11 “(e) IDENTIFICATIONS.—For purposes of subsection
12 (a)(4), the identifications described in this subsection are,
13 with respect to an applicable year, identifications of each
14 health care entity participating under the Medicare pro-
15 gram with respect to which another health care entity so
16 participating is a person with an ownership or control in-
17 terest (as defined in section 1124(a)(3)).

18 “(f) DEFINITIONS.—In this section:

19 “(1) AFFILIATED PHARMACY.—The term ‘affili-
20 ated pharmacy’ means, with respect to a Medicare
21 Advantage plan offered by a Medicare Advantage or-
22 ganization, a pharmacy with respect to which such
23 organization (or any person with an ownership or
24 control interest (as defined in section 1124(a)(3)) in

1 such organization) is a person with an ownership or
2 control interest (as so defined).

3 “(2) APPLICABLE YEAR.—The term ‘applicable
4 year’ means, with respect to a report submitted
5 under subsection (a), the first calendar year begin-
6 ning at least 4 years prior to the date of the submis-
7 sion of such report.

8 “(3) COVERED PART D DRUG.—The term ‘cov-
9 ered part D drug’ has the meaning given such term
10 in section 1860D–2(e).

11 “(4) DIRECT AND INDIRECT REMUNERATION.—
12 The term ‘direct and indirect remuneration’ has the
13 meaning given such term in section 423.308 of title
14 42, Code of Federal Regulations (or any successor
15 regulation).

16 “(5) QUALIFYING DIAGNOSIS.—The term ‘quali-
17 fying diagnosis’ means, with respect to an enrollee of
18 a Medicare Advantage plan, a diagnosis that is
19 taken into account in calculating a risk score for
20 such enrollee under the risk adjustment methodology
21 established by the Secretary pursuant to section
22 1853(a)(3).

23 “(6) RISK SCORE.—The term ‘risk score’
24 means, with respect to an enrollee of a Medicare Ad-

1 vantage plan, the score calculated for such individual
2 using the methodology described in paragraph (5).

3 “(7) PHYSICIAN-ADMINISTERED DRUG.—The
4 term ‘physician-administered drug’ means a drug
5 furnished to an individual that, had such individual
6 been enrolled under part B and not enrolled under
7 part C, would have been payable under section
8 1842(o).

9 “(8) SPECIFIED HEALTH CARE PROVIDER.—
10 The term ‘specified health care provider’ means,
11 with respect to a Medicare Advantage plan offered
12 by a Medicare Advantage organization, a health care
13 provider with respect to which such organization (or
14 any person with an ownership or control interest (as
15 defined in section 1124(a)(3)) in such organization)
16 is a person with an ownership or control interest (as
17 so defined).

18 “(9) SPECIFIED PHARMACY.—The term ‘speci-
19 fied pharmacy’ means, with respect to a prescription
20 drug plan offered by a prescription drug plan spon-
21 sor, a pharmacy with respect to which—

22 “(A) such sponsor (or any person with an
23 ownership or control interest (as defined in sec-
24 tion 1124(a)(3)) in such sponsor) is a person

1 with an ownership or control interest (as so de-
 2 fined); or

3 “(B) a pharmacy benefit manager offering
 4 services under such plan (or any person with an
 5 ownership or control interest (as so defined) in
 6 such sponsor) is a person with an ownership or
 7 control interest (as so defined).

8 “(10) SPECIFIED PHARMACY BENEFIT MAN-
 9 AGER.—The term ‘specified pharmacy benefit man-
 10 ager’ means, with respect to a prescription drug
 11 plan offered by a prescription drug plan sponsor, a
 12 pharmacy benefit manager with respect to which
 13 such sponsor (or any person with an ownership or
 14 control interest (as defined in section 1124(a)(3)) in
 15 such sponsor) is a person with an ownership or con-
 16 trol interest (as so defined).”.

17 **TITLE II—FAIR PRICES FOR** 18 **PATIENTS**

19 **SEC. 201. LIMITATION ON COST SHARING TO NET PRICE** 20 **AMOUNT UNDER MEDICARE PART D.**

21 (a) IN GENERAL.—Section 1860D–2 of the Social
 22 Security Act (42 U.S.C. 1395w–102) is amended—

23 (1) in subsection (b)—

24 (A) in paragraph (2)(A), by striking “(8)
 25 and (9)” and inserting “(8), (9), and (10)”;

1 (B) in paragraph (9)(B)(ii), by striking
 2 “For a plan year” and inserting “Subject to
 3 paragraph (10), for a plan year”; and

4 (C) by adding at the end the following new
 5 paragraph:

6 “(10) LIMITATION ON COST SHARING TO NET
 7 PRICE AMOUNT.—

8 “(A) IN GENERAL.—For a plan year begin-
 9 ning on or after January 1, 2027, the coverage
 10 provides benefits for a supply of a covered part
 11 D drug dispensed by a pharmacy, for costs in
 12 excess of the deductible specified in paragraph
 13 (1) and prior to an individual reaching the out-
 14 of-pocket threshold under paragraph (4), with
 15 cost-sharing for a month’s supply that does not
 16 exceed the average net price for such a supply
 17 of such drug during such plan year (or, if
 18 lower, the applicable cash price for such a sup-
 19 ply of such drug so dispensed by such phar-
 20 macy).

21 “(B) DEFINITIONS.—In this paragraph:

22 “(i) APPLICABLE CASH PRICE.—The
 23 term ‘applicable cash price’ means, with
 24 respect to a supply of a covered part D
 25 drug dispensed by a pharmacy, the price

1 that such pharmacy would charge for such
2 supply of such drug dispensed to an indi-
3 vidual without benefits for such drug
4 under any Federal health care program (as
5 defined in section 1128B), a group health
6 plan or group or individual health insur-
7 ance coverage (as such terms are defined
8 in section 2791 of the Public Health Serv-
9 ice Act), or the program established under
10 chapter 89 of title 5, United States Code.

11 “(ii) AVERAGE NET PRICE.—The term
12 ‘average net price’ means, with respect to
13 a supply of a covered part D drug, a pre-
14 scription drug plan, and a plan year, the
15 average amount paid under such plan (in-
16 cluding any amounts paid by an individual
17 enrolled under such plan as cost sharing
18 for such drug) as payment for such a sup-
19 ply of such drug dispensed during such
20 year, less any rebates or other forms of re-
21 munerations received under such plan with
22 respect to such drug.”; and

23 (2) in subsection (c), by adding at the end the
24 following new paragraph:

1 “(7) COST SHARING LIMITED TO NET PRICE.—

2 The coverage is provided in accordance with sub-
3 section (b)(10).”.

4 (b) CONFORMING AMENDMENT TO COST-SHARING
5 FOR LOW-INCOME INDIVIDUALS.—Section 1860D–
6 14(a)(1)(D)(iii) of the Social Security Act (42 U.S.C.
7 1395w–114(a)(1)(D)(iii)) is amended by adding at the
8 end the following new sentence: “For plan year 2027 and
9 subsequent plan years, the copayment amount applicable
10 under this clause to a supply of a covered part D drug
11 dispensed to the individual may not exceed the amount
12 provided under section 1860D–2(b)(10).”.

13 (c) GAO REPORT.—Not later than January 1, 2029,
14 the Comptroller General of the United States shall submit
15 to Congress a report containing—

16 (1) an analysis of compliance with the amend-
17 ments made by this section;

18 (2) an analysis of enforcement of such amend-
19 ments;

20 (3) recommendations with respect to improving
21 such enforcement; and

22 (4) recommendations relating to improving pub-
23 lic disclosure, and public awareness of, the require-
24 ments of such amendments.

1 **SEC. 202. REQUIRING A SEPARATE IDENTIFICATION NUM-**
2 **BER AND AN ATTESTATION FOR EACH OFF-**
3 **CAMPUS OUTPATIENT DEPARTMENT OF A**
4 **PROVIDER.**

5 (a) IN GENERAL.—Section 1833(t) of the Social Se-
6 curity Act (42 U.S.C. 1395l(t)) is amended by adding at
7 the end the following new paragraph:

8 “(23) USE OF UNIQUE HEALTH IDENTIFIERS;
9 ATTESTATION.—

10 “(A) IN GENERAL.—No payment may be
11 made under this subsection (or under an appli-
12 cable payment system pursuant to paragraph
13 (21)) for items and services furnished on or
14 after January 1, 2026, by an off-campus out-
15 patient department of a provider (as defined in
16 subparagraph (C)) unless—

17 “(i) such department has obtained,
18 and such items and services are billed
19 under, a standard unique health identifier
20 for health care providers (as described in
21 section 1173(b)) that is separate from
22 such identifier for such provider; and

23 “(ii) such provider has submitted to
24 the Secretary, during the 2-year period
25 ending on the date such items and services
26 are so furnished, an attestation that such

1 department is compliant with the require-
2 ments described in section 413.65 of title
3 42, Code of Federal Regulations (or a suc-
4 cessor regulation).

5 “(B) PROCESS FOR SUBMISSION AND RE-
6 VIEW.—Not later than 1 year after the date of
7 enactment of this paragraph, the Secretary
8 shall, through notice and comment rulemaking,
9 establish a process for each provider with an
10 off-campus outpatient department of a provider
11 to submit an attestation pursuant to subpara-
12 graph (A)(ii), and for the Secretary to review
13 each such attestation and determine, through
14 site visits, remote audits, or other means (as
15 determined appropriate by the Secretary),
16 whether such department is compliant with the
17 requirements described in such subparagraph.

18 “(C) OFF-CAMPUS OUTPATIENT DEPART-
19 MENT OF A PROVIDER DEFINED.—For purposes
20 of this paragraph, the term ‘off-campus out-
21 patient department of a provider’ means a de-
22 partment of a provider (as defined in section
23 413.65 of title 42, Code of Federal Regulations,
24 or any successor regulation) that is not lo-
25 cated—

1 “(i) on the campus (as defined in such
2 section) of such provider; or

3 “(ii) within the distance (described in
4 such definition of campus) from a remote
5 location of a hospital facility (as defined in
6 such section).”.

7 (b) HHS OIG ANALYSIS.—Not later than January
8 1, 2030, the Inspector General of the Department of
9 Health and Human Services shall submit to Congress—

10 (1) an analysis of the process established by the
11 Secretary of Health and Human Services to conduct
12 the reviews and determinations described in section
13 1833(t)(23)(B) of the Social Security Act, as added
14 by subsection (a) of this section; and

15 (2) recommendations based on such analysis, as
16 the Inspector General determines appropriate.

17 **SEC. 203. PARITY IN MEDICARE PAYMENTS FOR HOSPITAL**
18 **OUTPATIENT DEPARTMENT SERVICES FUR-**
19 **NISHED OFF-CAMPUS.**

20 (a) IN GENERAL.—Section 1833(t)(16) of the Social
21 Security Act (42 U.S.C. 1395l(t)(16)) is amended by add-
22 ing at the end the following new subparagraph:

23 “(H) PARITY IN FEE SCHEDULE AMOUNT
24 FOR CERTAIN SERVICES FURNISHED BY AN

1 OFF-CAMPUS OUTPATIENT DEPARTMENT OF A
2 PROVIDER.—

3 “(i) IN GENERAL.—Subject to clause
4 (iii), in the case of specified OPD services
5 (as defined in clause (v)) that are fur-
6 nished during 2025 or a subsequent year
7 by an off-campus outpatient department of
8 a provider (as defined in clause (iv)) (or,
9 in the case of an off-campus outpatient de-
10 partment of a provider that is a hospital
11 described in section 1886(d)(1)(B)(v), or is
12 located in a rural area or a health profes-
13 sional shortage area, such services that are
14 furnished during 2026 or a subsequent
15 year), there shall be substituted for the
16 amount otherwise determined under this
17 subsection for such service and year an
18 amount equal to the payment amount that
19 would have been payable under the applica-
20 ble payment system under this part (other
21 than under this subsection) had such serv-
22 ices been furnished by such a department
23 subject to such payment system pursuant
24 to paragraph (21)(C).

1 “(ii) NOT BUDGET NEUTRAL IMPLE-
2 MENTATION.—In making any budget neu-
3 trality adjustments under this subsection
4 for 2025 or a subsequent year, the Sec-
5 retary shall not take into account the re-
6 duced expenditures that result from the
7 application of this subparagraph.

8 “(iii) TRANSITION.—The Secretary
9 shall provide for a 4-year phase-in of the
10 application of clause (i), with clause (i)
11 being fully applicable for specified OPD
12 services beginning with 2028 (or in the
13 case of an off-campus outpatient depart-
14 ment of a provider that is a hospital de-
15 scribed in section 1886(d)(1)(B)(v), or is
16 located in a rural area or a health profes-
17 sional shortage area, beginning with 2029).

18 “(iv) OFF-CAMPUS DEPARTMENT OF A
19 PROVIDER.—For purposes of this subpara-
20 graph, the term ‘off-campus outpatient de-
21 partment of a provider’ means a depart-
22 ment of a provider (as defined in section
23 413.65(a)(2) of title 42, Code of Federal
24 Regulations) that is not located—

1 “(I) on the campus (as such term
2 is defined in such section) of such
3 provider; or

4 “(II) within the distance (de-
5 scribed in such definition of campus)
6 from a remote location of a hospital
7 facility (as defined in such section).

8 “(v) OTHER DEFINITIONS.—For pur-
9 poses of this subparagraph:

10 “(I) DESIGNATED AMBULATORY
11 PAYMENT CLASSIFICATION GROUP.—
12 The term ‘designated ambulatory pay-
13 ment classification group’ means an
14 ambulatory payment classification
15 group for drug administration serv-
16 ices.

17 “(II) HEALTH PROFESSIONAL
18 SHORTAGE AREA.—The term ‘health
19 professional shortage area’ has the
20 meaning given such term in section
21 332(a)(1)(A) of the Public Health
22 Service Act.

23 “(III) RURAL AREA.—The term
24 ‘rural area’ has the meaning given
25 such term in section 1886(d)(2)(D).

1 “(IV) SPECIFIED OPD SERV-
2 ICES.—The term ‘specified OPD serv-
3 ices’ means covered OPD services as-
4 signed to a designated ambulatory
5 payment classification group.”.

6 (b) IMPLEMENTATION.—Section 1833(t)(12) of the
7 Social Security Act (42 U.S.C. 1395l(t)(12)) is amend-
8 ed—

9 (1) in subparagraph (D), by striking “and” at
10 the end;

11 (2) in subparagraph (E), by striking the period
12 at the end and inserting “; and”; and

13 (3) by adding at the end the following new sub-
14 paragraph:

15 “(F) the determination of any payment
16 amount under paragraph (16)(H), including the
17 transition under clause (iii) of such para-
18 graph.”.

**TITLE III—PATIENT-FOCUSED
INVESTMENTS**

**SEC. 301. ESTABLISHING REQUIREMENTS WITH RESPECT
TO THE USE OF PRIOR AUTHORIZATION
UNDER MEDICARE ADVANTAGE PLANS.**

(a) IN GENERAL.—Section 1852 of the Social Security Act (42 U.S.C. 1395w–22) is amended by adding at the end the following new subsection:

“(o) PRIOR AUTHORIZATION REQUIREMENTS.—

“(1) IN GENERAL.—In the case of a Medicare Advantage plan that imposes any prior authorization requirement with respect to any applicable item or service (as defined in paragraph (5)) during a plan year, such plan shall—

“(A) beginning with the third plan year beginning after the date of the enactment of this subsection—

“(i) establish the electronic prior authorization program described in paragraph (2); and

“(ii) meet the enrollee protection standards specified pursuant to paragraph (4); and

“(B) beginning with the fourth plan year beginning after the date of the enactment of

1 this subsection, meet the transparency require-
2 ments specified in paragraph (3).

3 “(2) ELECTRONIC PRIOR AUTHORIZATION PRO-
4 GRAM.—

5 “(A) IN GENERAL.—For purposes of para-
6 graph (1)(A), the electronic prior authorization
7 program described in this paragraph is a pro-
8 gram that provides for the secure electronic
9 transmission of—

10 “(i) a prior authorization request
11 from a provider of services or supplier to
12 a Medicare Advantage plan with respect to
13 an applicable item or service to be fur-
14 nished to an individual and a response, in
15 accordance with this paragraph, from such
16 plan to such provider or supplier; and

17 “(ii) any attachment relating to such
18 request or response.

19 “(B) ELECTRONIC TRANSMISSION.—

20 “(i) EXCLUSIONS.—For purposes of
21 this paragraph, a facsimile, a proprietary
22 payer portal that does not meet standards
23 specified by the Secretary, or an electronic
24 form shall not be treated as an electronic

transmission described in subparagraph
(A).

“(ii) STANDARDS.—An electronic
transmission described in subparagraph
(A) shall comply with—

“(I) applicable technical stand-
ards adopted by the Secretary pursu-
ant to section 1173; and

“(II) other requirements to pro-
mote the standardization and stream-
lining of electronic transactions under
this part specified by the Secretary.

“(iii) DEADLINE FOR SPECIFICATION
OF ADDITIONAL REQUIREMENTS.—Not
later than July 1, 2024, the Secretary
shall finalize requirements described in
clause (ii)(II).

“(C) REAL-TIME DECISIONS.—

“(i) IN GENERAL.—Subject to clause
(iv), the program described in subpara-
graph (A) shall provide for real-time deci-
sions (as defined by the Secretary in ac-
cordance with clause (v)) by a Medicare
Advantage plan with respect to prior au-
thorization requests for applicable items

1 and services identified by the Secretary
2 pursuant to clause (ii) if such requests are
3 submitted with all medical or other docu-
4 mentation required by such plan.

5 “(ii) IDENTIFICATION OF ITEMS AND
6 SERVICES.—

7 “(I) IN GENERAL.—For purposes
8 of clause (i), the Secretary shall iden-
9 tify, not later than the date on which
10 the initial announcement described in
11 section 1853(b)(1)(B)(i) for the third
12 plan year beginning after the date of
13 the enactment of this subsection is re-
14 quired to be announced, applicable
15 items and services for which prior au-
16 thorization requests are routinely ap-
17 proved.

18 “(II) UPDATES.—The Secretary
19 shall consider updating the applicable
20 items and services identified under
21 subclause (I) based on the information
22 described in paragraph (3)(A)(i) (if
23 available and determined practicable
24 to utilize by the Secretary) and any
25 other information determined appro-

1 prate by the Secretary not less fre-
2 quently than biennially. The Secretary
3 shall announce any such update that
4 is to apply with respect to a plan year
5 not later than the date on which the
6 initial announcement described in sec-
7 tion 1853(b)(1)(B)(i) for such plan
8 year is required to be announced.

9 “(iii) REQUEST FOR INFORMATION.—

10 The Secretary shall issue a request for in-
11 formation for purposes of initially identi-
12 fying applicable items and services under
13 clause (ii)(I).

14 “(iv) EXCEPTION FOR EXTENUATING

15 CIRCUMSTANCES.—In the case of a prior
16 authorization request submitted to a Medi-
17 care Advantage plan for an individual en-
18 rolled in such plan during a plan year with
19 respect to an item or service identified by
20 the Secretary pursuant to clause (ii) for
21 such plan year, such plan may, in lieu of
22 providing a real-time decision with respect
23 to such request in accordance with clause
24 (i), delay such decision under extenuating
25 circumstances (as specified by the Sec-

1 retary), provided that such decision is pro-
2 vided no later than 72 hours after receipt
3 of such request (or, in the case that the
4 provider of services or supplier submitting
5 such request has indicated that such delay
6 may seriously jeopardize such individual's
7 life, health, or ability to regain maximum
8 function, no later than 24 hours after re-
9 ceipt of such request).

10 “(v) DEFINITION OF REAL-TIME DECI-
11 SION.—In establishing the definition of a
12 real-time decision for purposes of clause
13 (i), the Secretary shall take into account
14 current medical practice, technology,
15 health care industry standards, and other
16 relevant information relating to how quick-
17 ly a Medicare Advantage plan may provide
18 responses with respect to prior authoriza-
19 tion requests.

20 “(vi) IMPLEMENTATION.—The Sec-
21 retary shall use notice and comment rule-
22 making for each of the following:

23 “(I) Establishing the definition
24 of a ‘real-time decision’ for purposes
25 of clause (i).

1 “(II) Updating such definition.

2 “(III) Initially identifying appli-
3 cable items or services pursuant to
4 clause (ii)(I).

5 “(IV) Updating applicable items
6 and services so identified as described
7 in clause (ii)(II).

8 “(3) TRANSPARENCY REQUIREMENTS.—

9 “(A) IN GENERAL.—For purposes of para-
10 graph (1)(B), the transparency requirements
11 specified in this paragraph are, with respect to
12 a Medicare Advantage plan, the following:

13 “(i) The plan, annually and in a man-
14 ner specified by the Secretary, shall submit
15 to the Secretary the following information:

16 “(I) A list of all applicable items
17 and services that were subject to a
18 prior authorization requirement under
19 the plan during the previous plan
20 year.

21 “(II) The percentage and number
22 of specified requests (as defined in
23 subparagraph (F)) approved during
24 the previous plan year by the plan in
25 an initial determination and the per-

1 centage and number of specified re-
2 quests denied during such plan year
3 by such plan in an initial determina-
4 tion (both in the aggregate and cat-
5 egorized by each item and service).

6 “(III) The percentage and num-
7 ber of specified requests submitted
8 during the previous plan year that
9 were made with respect to an item or
10 service identified by the Secretary
11 pursuant to paragraph (2)(C)(ii) for
12 such plan year, and the percentage
13 and number of such requests that
14 were subject to an exception under
15 paragraph (2)(C)(iv) (categorized by
16 each item and service).

17 “(IV) The percentage and num-
18 ber of specified requests submitted
19 during the previous plan year that
20 were made with respect to an item or
21 service identified by the Secretary
22 pursuant to paragraph (2)(C)(ii) for
23 such plan year that were approved
24 (categorized by each item and serv-
25 ice).

1 “(V) The percentage and number
2 of specified requests that were denied
3 during the previous plan year by the
4 plan in an initial determination and
5 that were subsequently appealed.

6 “(VI) The number of appeals of
7 specified requests resolved during the
8 preceding plan year, and the percent-
9 age and number of such resolved ap-
10 peals that resulted in approval of the
11 furnishing of the item or service that
12 was the subject of such request, cat-
13 egorized by each applicable item and
14 service and categorized by each level
15 of appeal (including judicial review).

16 “(VII) The percentage and num-
17 ber of specified requests that were de-
18 nied, and the percentage and number
19 of specified requests that were ap-
20 proved, by the plan during the pre-
21 vious plan year through the utilization
22 of decision support technology, artifi-
23 cial intelligence technology, machine-
24 learning technology, clinical decision-

1 making technology, or any other tech-
2 nology specified by the Secretary.

3 “(VIII) The average and the me-
4 dian amount of time (in hours) that
5 elapsed during the previous plan year
6 between the submission of a specified
7 request to the plan and a determina-
8 tion by the plan with respect to such
9 request for each such item and serv-
10 ice, excluding any such requests that
11 were not submitted with the medical
12 or other documentation required to be
13 submitted by the plan.

14 “(IX) The percentage and num-
15 ber of specified requests that were ex-
16 cluded from the calculation described
17 in subclause (VIII) based on the
18 plan’s determination that such re-
19 quests were not submitted with the
20 medical or other documentation re-
21 quired to be submitted by the plan.

22 “(X) Information on each occur-
23 rence during the previous plan year in
24 which, during a surgical or medical
25 procedure involving the furnishing of

1 an applicable item or service with re-
2 spect to which such plan had ap-
3 proved a prior authorization request,
4 the provider of services or supplier
5 furnishing such item or service deter-
6 mined that a different or additional
7 item or service was medically nec-
8 essary, including a specification of
9 whether such plan subsequently ap-
10 proved the furnishing of such dif-
11 ferent or additional item or service.

12 “(XI) A disclosure and descrip-
13 tion of any technology described in
14 subclause (VII) that the plan utilized
15 during the previous plan year in mak-
16 ing determinations with respect to
17 specified requests.

18 “(XII) The number of grievances
19 (as described in subsection (f)) re-
20 ceived by such plan during the pre-
21 vious plan year that were related to a
22 prior authorization requirement.

23 “(XIII) Such other information
24 as the Secretary determines appro-
25 priate.

1 “(ii) The plan shall provide—

2 “(I) to each provider or supplier
3 who seeks to enter into a contract
4 with such plan to furnish applicable
5 items and services under such plan,
6 the list described in clause (i)(I) and
7 any policies or procedures used by the
8 plan for making determinations with
9 respect to prior authorization re-
10 quests;

11 “(II) to each such provider and
12 supplier that enters into such a con-
13 tract, access to the criteria used by
14 the plan for making such determina-
15 tions and an itemization of the med-
16 ical or other documentation required
17 to be submitted by a provider or sup-
18 plier with respect to such a request;
19 and

20 “(III) to an enrollee of the plan,
21 upon request, access to the criteria
22 used by the plan for making deter-
23 minations with respect to prior au-
24 thorization requests for an item or
25 service.

1 “(B) OPTION FOR PLAN TO PROVIDE CER-
2 TAIN ADDITIONAL INFORMATION.—As part of
3 the information described in subparagraph
4 (A)(i) provided to the Secretary during a plan
5 year, a Medicare Advantage plan may elect to
6 include information regarding the percentage
7 and number of specified requests made with re-
8 spect to an individual and an item or service
9 that were denied by the plan during the pre-
10 ceding plan year in an initial determination
11 based on such requests failing to demonstrate
12 that such individuals met the clinical criteria
13 established by such plan to receive such items
14 or services.

15 “(C) REGULATIONS.—The Secretary shall,
16 through notice and comment rulemaking, estab-
17 lish requirements for Medicare Advantage plans
18 regarding the provision of—

19 “(i) access to criteria described in
20 subparagraph (A)(ii)(II) to providers of
21 services and suppliers in accordance with
22 such subparagraph; and

23 “(ii) access to such criteria to enroll-
24 ees in accordance with subparagraph
25 (A)(ii)(III).

1 “(D) PUBLICATION OF INFORMATION.—

2 The Secretary shall publish information de-
3 scribed in subparagraph (A)(i) and subpara-
4 graph (B) on a public website of the Centers
5 for Medicare & Medicaid Services. Such infor-
6 mation shall be so published on an individual
7 plan level and may in addition be aggregated in
8 such manner as determined appropriate by the
9 Secretary.

10 “(E) MEDPAC REPORT.—Not later than 3

11 years after the date information is first sub-
12 mitted under subparagraph (A)(i), the Medicare
13 Payment Advisory Commission shall submit to
14 Congress a report on such information that in-
15 cludes a descriptive analysis of the use of prior
16 authorization. As appropriate, the Commission
17 should report on statistics including the fre-
18 quency of appeals and overturned decisions.
19 The Commission shall provide recommenda-
20 tions, as appropriate, on any improvement that
21 should be made to the electronic prior author-
22 ization programs of Medicare Advantage plans.

23 “(F) SPECIFIED REQUEST DEFINED.—For

24 purposes of this paragraph, the term ‘specified
25 request’ means a prior authorization request

1 made with respect to an applicable item or serv-
2 ice.

3 “(4) ENROLLEE PROTECTION STANDARDS.—
4 For purposes of paragraph (1)(A)(ii), with respect
5 to the use of prior authorization by Medicare Advan-
6 tage plans for applicable items and services, the en-
7 rollee protection standards specified in this para-
8 graph are—

9 “(A) the adoption of transparent prior au-
10 thorization programs developed in consultation
11 with enrollees and with providers and suppliers
12 with contracts in effect with such plans for fur-
13 nishing such items and services under such
14 plans;

15 “(B) allowing for the waiver or modifica-
16 tion of prior authorization requirements based
17 on the performance of such providers and sup-
18 pliers in demonstrating compliance with such
19 requirements, such as adherence to evidence-
20 based medical guidelines and other quality cri-
21 teria; and

22 “(C) conducting annual reviews of such
23 items and services for which prior authorization
24 requirements are imposed under such plans
25 through a process that takes into account input

1 from enrollees and from providers and suppliers
2 with such contracts in effect and is based on
3 consideration of prior authorization data from
4 previous plan years and analyses of current cov-
5 erage criteria.

6 “(5) APPLICABLE ITEM OR SERVICE DE-
7 FINED.—For purposes of this subsection, the term
8 ‘applicable item or service’ means, with respect to a
9 Medicare Advantage plan, any item or service for
10 which benefits are available under such plan, other
11 than a covered part D drug.

12 “(6) REPORTS TO CONGRESS.—

13 “(A) GAO.—Not later than the end of the
14 fourth plan year beginning on or after the date
15 of the enactment of this subsection, the Comp-
16 troller General of the United States shall sub-
17 mit to Congress a report containing an evalua-
18 tion of the implementation of the requirements
19 of this subsection and an analysis of issues in
20 implementing such requirements faced by Medi-
21 care Advantage plans.

22 “(B) HHS.—Not later than the end of the
23 fifth plan year beginning after the date of the
24 enactment of this subsection, and biennially
25 thereafter through the date that is 10 years

after such date of enactment, the Secretary shall submit to Congress a report containing a description of the information submitted under paragraph (3)(A)(i) during—

“(i) in the case of the first such report, the fourth plan year beginning after the date of the enactment of this subsection; and

“(ii) in the case of a subsequent report, the 2 plan years preceding the year of the submission of such report.”.

(b) ENSURING TIMELY RESPONSES FOR ALL PRIOR AUTHORIZATION REQUESTS SUBMITTED UNDER PART C.—Section 1852(g) of the Social Security Act (42 U.S.C. 1395w-22(g)) is amended—

(1) in paragraph (1)(A), by inserting “and in accordance with paragraph (6)” after “paragraph (3)”;

(2) in paragraph (3)(B)(iii), by inserting “(or, subject to subsection (o), with respect to prior authorization requests submitted on or after the first day of the third plan year beginning after the date of the enactment of the **【Improving Seniors’ Timely Access to Care Act of 2023】**, not later than 24 hours)” after “72 hours”.

1 (3) by adding at the end the following new
2 paragraph:

3 “(6) TIMEFRAME FOR RESPONSE TO PRIOR AU-
4 THORIZATION REQUESTS.—Subject to paragraph (3)
5 and subsection (o), in the case of an organization
6 determination made with respect to a prior author-
7 ization request for an item or service to be furnished
8 to an individual submitted on or after the first day
9 of the third plan year beginning after the date of the
10 enactment of this paragraph, the organization shall
11 notify the enrollee (and the physician involved, as
12 appropriate) of such determination no later than 7
13 days (or such shorter timeframe as the Secretary
14 may specify through notice and comment rule-
15 making, taking into account enrollee and stakeholder
16 feedback) after receipt of such request.”.

17 (c) RULE OF CONSTRUCTION.—None of the amend-
18 ments made by this section may be construed to affect
19 the finalization of the proposed rule entitled “Medicare
20 and Medicaid Programs; Patient Protection and Afford-
21 able Care Act; Advancing Interoperability and Improving
22 Prior Authorization Processes for Medicare Advantage Or-
23 ganizations, Medicaid Managed Care Plans, State Med-
24 icaid Agencies, Children’s Health Insurance Program
25 (CHIP) Agencies and CHIP Managed Care Entities,

1 Issuers of Qualified Health Plans on the Federally Facili-
2 tated Exchanges, Merit-Based Incentive Payment System
3 (MIPS) Eligible Clinicians, and Eligible Hospitals and
4 Critical Access Hospitals in the Medicare Promoting
5 Interoperability Program” published on December 13,
6 2022 (87 Fed. Reg. 76238), or application of such rule
7 so finalized, for plan years before the third plan year be-
8 ginning on or after the date of the enactment of this Act.

9 **SEC. 302. EXTENSION OF CERTAIN DIRECT SPENDING RE-**
10 **DUCTIONS.**

11 Section 251A(6)(D) of the Balanced Budget and
12 Emergency Deficit Control Act of 1985 (901a(6)(D)) is
13 amended—

14 (1) in clause (i), by striking “; and” and insert-
15 ing a semicolon;

16 (2) in clause (ii), by striking “second 6 months
17 in which such order is effective for such fiscal year,
18 the payment reduction shall be 0 percent.” and in-
19 serting “2 month period beginning on the day after
20 the last day of the period described in clause (i) in
21 which such order is effective for such fiscal year, the
22 payment reduction shall be 1.5 percent; and”; and

23 (3) by adding at the end the following new
24 clause:

1 “(iii) with respect to the last 4
2 months in which such order is effective for
3 such fiscal year, the payment reduction
4 shall be 0 percent.”.

○